LEGISLATIVE PROPOSALS REGARDING THE VA'S HEALTH CARE SYSTEM

HEARING

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

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LEGISLATIVE PROPOSALS REGARDING THE VA'S HEALTH CARE SYSTEM

Wednesday, May 20, 1987

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9 a.m., in room 334, Cannon House Office Building, Hon. G. V. (Sonny) Montgomery (chairman of the subcommittee) presiding.

Present: Representatives Montgomery, Penny, Staggers, Rowland of Georgia, Robinson, Stenholm, Kennedy, Hammerschmidt, McEwen, Smith of New Jersey, Bilirakis, and Rowland of Connecticut.

Also Present: Representatives Evans and Solomon.

OPENING STATEMENT OF CHAIRMAN MONTGOMERY

Mr. MONTGOMERY. It's 9 o'clock and the committee will come to order.

The topics this morning are many, but they all relate to improving the delivery of medical care services to our Nation's veterans.

In order to easily describe the variety of legislative issues that will be considered this morning, I have grouped them into six areas. Certainly, the order in which I will discuss the areas and the number of topics within any one area are not in any way intended to reflect relative importance of any single issue. Where bill numbers are not noted, the provisions are contained in a draft bill which I and the ranking minority member of this subcommittee, Mr. Hammerschmidt, will introduce in the near future.

One area consists of a measure that was introduced by the ranking minority member, Gerry Solomon. The measure is H.R. 2327, a bill to require that the VA provide beneficiary travel to certain service-connected and low-income veterans.

Another area consists of a measure that was introduced by the chairman of the Subcommittee on Oversight and Investigations, Lane Evans, who will be here in just a few minutes. The measure is H.R. 2146, a bill to extend the transition period for the vet center program from one providing counseling services primarily through storefront locations to one through VA general health care facilities.

Other issues consist of legislation to assist the VA in recruitment and retention of health care personnel, especially nurses and phar-

macists. There are several provisions in this area that we will discuss during the hearing:

The reintroduction of a pilot program on hospital management efficiency, which I introduced last year, was passed by the House and was rejected in conference with the Senate. The Senate objected to it.

Also, important changes in eligibility for VA outpatient care, domiciliary care, and nursing home care, and provisions that would provide care for veterans who are homeless and those with chronic psychiatric disabilities, and modify the organization and functions of the Chief Medical Director's office.

So you can see we are pretty busy this morning. We will hear first from the ranking minority member of the Hospitals and Health Care Subcommittee, John Paul Hammerschmidt.

OPENING STATEMENT OF HON. JOHN PAUL HAMMERSCHMIDT

Mr. HAMMERSCHMIDT. Thank you very much, Mr. Chairman.

Our focus today, as it always is, is on improving the Veterans' Administration medical program. The several bills before us, as well as the draft legislation, cover a number of areas of concern—and I believe you said you broke it up into six categories. I am sure that our witnesses will speak to each of them. Mr. Chairman, let me speak briefly to some of those areas.

Last year we in the House sought to establish a pilot program on management efficiency in the Department of Medicine and Surgery. The other body would not concur. However, we all agreed, I think, to pursue the matter further. It is my hope that we will do this during this session of Congress. It seems to me that the results of such a program designed to let hospital managers really manage—unfettered by a multitude of administrative rules and regulations—but yet be held accountable for results and prudence, can only be good for VA medicine and good for the Government.

Mr. Chairman, as you mentioned, our ranking member, Mr. Solomon, with your aid and assistance, is the chief sponsor of a bill to restore beneficiary travel for sick and disabled veterans to a realistic and necessary level. The bill now has at least 172 cosponsors, including almost all the membership of this committee. In my view, we ought to fast-track this bill. I appreciate your great help in this regard, and certainly Mr. Solomon's initiative.

Mr. Chairman, during the last Congress we mandated inpatient medical care for certain priority veterans. The program is working well. The apprehensions of some about this new procedure have simply not materialized and, in my view, they will not. It seems to me that we could also consider mandating such care for priority outpatients, some of whom are reportedly turned away from VA medical facilities. In such consideration, of course, we need to know possible impacts on the total VA system, as well as on the patients.

Mr. Chairman, one of the bills before us extends the transition period for the vet center counseling program. The transition is concerned with where such counseling service would be provided, either at storefront type locations or at VA medical centers. I favor the 1-year extension primarily because a scheduled report to the Congress about this subject has not yet been received.

However, in all candor, Mr. Chairman, it needs to be stated that ultimate decisions about locations of these centers ought to be based on the best medical judgments of the Veterans' Administration. Moreover, it also needs to be stated that current actions with respect to the nine places where the VA has proposed relocation to medical centers does not in any way spell doom for this program, as suggested by some critics of this action.

Mr. Chairman, the other matters before us are designed to fine-tune VA medicine. They involve a number of important aspects of the medical program. Each of these deserve our careful study and consideration.

Mr. Chairman, I commend you for scheduling this hearing on these vital subjects. I am also delighted to be with our ranking member, Mr. Solomon, and I look forward to hearing our witnesses testify on each of these subjects.

Thank you, Mr. Chairman.

Mr. MONTGOMERY. Thank you, John Paul.

I have two comments before recognizing Gerry Solomon. One, there are a number of people in the room today, especially the Members, who helped on the passage of the GI bill and to make it permanent legislation. I think we all enjoyed the signing ceremony of the enrolled bill. Again, I want to thank the Members, as well as our guests in the audience today, who participated in this historic matter. It is the first time that can be recalled, for the old-timers or anyone else, where an enrolled bill was done in a ceremony status, such as was done in Statutory Hall.

Also, Dr. Gronvall, I haven't talked to staff, nor have I talked to Mr. Solomon or Mr. Hammerschmidt, but when you come up this morning as a witness, you might comment on this article in the Washington Post this morning. As I understand it, we are not planning on having a press conference on this side, but I understand that Senator Cranston and Senator Murkowski are having a press conference this morning on the Senate side. We would just like to get some input for the record, if you have no objection to that, Gerry, or John Paul.

Mr. SOLOMON. Absolutely not.

Mr. MONTGOMERY. Gerry, I would like to recognize you at this time.

STATEMENT OF HON. GERALD B.H. SOLOMON

Mr. SOLOMON. Thank you, Mr. Chairman.

First of all, let's continue on the subject that you brought up, and that is the Montgomery GI bill. Again, I just want to publicly take off my hat to you for the way that you handled the peacetime GI bill, from its very beginning to its fruition—and we're sure the President is going to sign it—making permanent the peacetime GI bill. You did a miraculous job and we all take off our hats to you.

As I said at the ceremony yesterday, Sonny is something else, and if I ever had to go to war, I sure want you at my side.

Mr. MONTGOMERY. You also added, if I would go in the Marines.

[Laughter.]

Mr. SOLOMON. Mr. Chairman, let's go on to the other subject here. I am not going down to the table to testify. I think we're all a family and I can do it from up here.

Mr. Chairman, John Paul, and members of the subcommittee, it is a pleasure to change roles and testify before my favorite committee, especially when it is for something I feel very strongly about, as I do on this issue.

With the cosponsorship of nearly all of the members of our committee, including you, Mr. Chairman, and John Paul—who are not just cosponsors but sponsors of this bill—I have introduced H.R. 2327, to restore beneficiary travel benefits to many veterans who lost eligibility when the Veterans' Administration changed its travel regulations a little over a month ago. In fact, when introduced, as John Paul has said, the bipartisan bill had 125 cosponsors, and now it has 172, and I am sure we will have more than 200 before the week is out. The broad support for the bill reflects the extent of recognition that deserving veterans are being hurt by the drastic cutbacks in travel reimbursement. If the VA wants to save money, if it needs to save money, if it is being forced to save money, whatever the reasons, it certainly should not be at the expense of low-income and disabled service-connected veterans.

I firmly believe the VA should do what is right when it comes to veterans' medical care, and if a disabled or low-income veteran cannot get to a VA medical facility, eligibility for that treatment doesn't mean much. It doesn't matter how many hospitals we have or how much service we can render; if they can't get there, then we might as well not have any.

Our committee has been keeping a careful eye on the beneficiary travel situation ever since late last year when we learned that the VA was proposing to change travel eligibility. We included in our report to the Budget Committee last February 25 an expression of concern about the sufficiency of funding for that program.

Today, the situation faced by many veterans is urgent, and I want to personally commend and thank you, Mr. Chairman, for your recognition of the need to put this bill on a fast track. Not many bills have a hearing 13 days after being introduced. The subcommittee markup is set for June 3, and the full committee markup is set for June 10, due to the high priority you have given this particular piece of legislation.

I understand that Senator Chafee is introducing an identical bill in the Senate, and hopefully our colleagues in the other body will accord this legislation a similar priority.

Specifically, H.R. 2327 will provide beneficiary travel payments to, number one, service-connected veterans for treatment of their service-connected disabilities; number two, service-connected veterans who are disabled 50 percent or more for treatment of any disability; three, veterans who receive a VA pension; four, low-income veterans who do not have an annual income exceeding the maximum annual amount of a VA pension; number five, veterans needed special mode transportation, such as ambulance or wheelchair vans, who cannot afford such transportation; and number six, any other person who the VA determines to be unable to afford transportation, or who for other reasons should be provided transportation.

Most of the veterans who were eligible before the April 13 change will have their eligibility restored. I believe the bill provides a fair and equitable basis for reimbursing for travel. The types of travel and purposes of travel would be the same as under the old regulations.

Mr. Chairman, it was apparently an overreaction to cost problems which resulted in the VA's severe restriction of eligibility last year. Certainly cost in these days of budgetary restraint is not to be ignored. But the VA is already planning to spend $52 million for fiscal year 1988 under its reduced level of travel benefits.

The Congressional Budget Office tells us that this bill would cost an additional $45 million, just $45 million. Yet, the $97 million for fiscal year 1988 would still be $30 million less than the VA would have spent under the old regulations for that fiscal year. It is no secret that I'm about as careful with the taxpayers' dollars as any Member of this Congress, and when I propose something like this, I certainly don't do it lightly.

Where will the additional $45 million come from? The question is a legitimate one and it should be asked and answered. To be realistic, funding for additional beneficiary travel could well come through reprogramming. However, concerns have been expressed that direct medical care will be reduced to make up for increased travel expenditures.

I believe very strongly that with careful management and a hard look at priorities, the VA can find $45 million in a medical care budget of almost $11 billion without impacting hands-on medical care. I believe this can be done. But should a problem arise that would directly affect the delivery of medical care, I am sure that this committee would exert enough pressure to bring about some relief in a supplemental appropriation or do whatever else we had to do. So I do not accept VA testimony that it can't find this money. I think we can handle it.

Mr. Chairman, service-connected and low-income veterans must be provided the means for travel to their necessary medical care. To me, that is an essential part of what the Nation's commitment to veterans is all about.

I think we just have to say to OMB, we have to say to the Veterans' Administration, and to the White House, with all good intentions—and I am sure that they all want to do what is right by the veterans—but this committee and this Congress is not going to entertain any kind of proposal that those people would come up with that is going to diminish veterans' benefits. We have a commitment to these veterans, and we have not in this committee come up with lavish or extravagant spending programs. We came up with a budget this year which merely maintains what we have, with some very modest increases on things like aid to the homeless that we have to deal with. But we have been fiscally responsible.

We just want to send a message to OMB, that it might as well not put the pressure on the VA and put the pressure on whoever else to come in here and diminish veterans' programs, because we're just not going to stand for it. That is exactly what we're doing here today. We are going to be fiscally responsible and we are going to restore this beneficiary travel to what is reasonable, and we're going to fight it through until it is enacted into law.

Mr. Chairman and John Paul, I really do appreciate all of your help, of the subcommittee and of the full committee. Thank you very much.

Mr. MONTGOMERY. Thank you for that very strong statement. The only thing I could add is I'm a cosponsor of the legislation, as well as John Paul and others on this side of the aisle. We will push ahead on the schedule that you mentioned.

The Chair would like to recognize Chairman Lane Evans of the Subcommittee on Oversight and Investigations.

Mr. EVANS. Thank you, Mr. Chairman. I appreciate the opportunity to sit in on this panel. I am not a member of the subcommittee, so I appreciate you letting me participate today.

I appreciate the several issues you will be considering, most notably the legislation I have introduced, along with many of my colleagues on this committee, proposing an extension for the VA's readjustment counseling program, H.R. 2146. I look forward to the testimony of the veterans' service organizations, along with the VA, regarding this legislation.

I again want to thank you for your interest and support regarding this concern, and I again congratulate you on the Montgomery GI bill.

Mr. MONTGOMERY. Thank you for offering that amendment.

Dr. Roy Rowland.

Dr. ROWLAND of Georgia. Thank you, Mr. Chairman. I can't tell you how pleased I was about the way everything came out on our permanent GI bill. I think it was just great and you've done a fantastic job with that. I am so pleased.

There is a lot of work before us here this morning. I appreciate you having this hearing and I won't take much time.

It wasn't many weeks ago that we had a hearing about the shortage of VA health care personnel. That hearing left no question about the general shortage of nurses and pharmacists in VA hospitals and shortages of other health care professions at certain hospitals. Of all the components of medical care today, I don't believe there is anything more important than having qualified staff.

There are some items on the agenda today that might help to alleviate the shortage of nurses and pharmacists. In addition, I have an idea that is specifically oriented towards the easing of the nursing shortage.

No one is more aware of the budget and deficit problems than Members of Congress. Yet, I am disappointed that the VA opposes all of the health care personnel items that we have put forward. I hope in the interest of high quality health care that the agengy will reconsider some of its positions.

Another important item concerns the location of the vet center program and whether the vet centers will be separate from or together with VA facilities. I just want to say that Vietnam veterans must receive excellent care, not only psychological care but other health care in an environment where we can expect the best results. It is also my hope that the distinction can be ended between veterans of the Vietnam era and veterans of other times in our history.

Beneficiary travel will be discussed today, also. It is an important ingredient of obtaining medical care for many veterans. I

think Gerry Solomon has done a good job in identifying that group of veterans for whom travel is a problem and in finding a middle position between meeting needs and watching the budget.

I just want to say that many other items are important, too, but I would point out for all of our witnesses that in the crush of the legislative schedule it seems that it's required we have to put so much on the agenda today.

Mr. Chairman, I thank you.

Mr. MONTGOMERY. Thank you, Roy, and Lane Evans. I think what you're trying to do has some merit on these storefront operations.

Also, Dr. Rowland, we are coming up with some real problems on shortages of nurses. We have seen it throughout the Federal Government, especially on the military side, and in the Veterans' Administration.

Dr. ROWLAND of Georgia. Mr. Chairman, there is also a shortage in the private sector, too, so that really does cause a crunch in all areas.

Mr. MONTGOMERY. We've had it before and we pretty well have gotten on top of it. We just have to do the same thing again.

Both of you gentlemen mentioned the GI bill. I don't want to embarrass anyone in any way, but Miss Arlene Burnett, who is our office manager, is the mother of one of the soldiers at the signing ceremonies yesterday. He signed up for the GI bill. He's Regular Army and they sent him to Korea. So we see right in our own family how this legislation has been involved.

The Honorable Sherwood Boehlert of New York was one of our witnesses. I don't believe he is here. We will put his statement in the record.

[The prepared statement of Congressman Boehlert appears at p. 86.]

Mr. MONTGOMERY. If the members don't have any other comments, we will call our first panel. Panel one is David Gorman, Disabled American Veterans, James Magill, VFW, and Mr. Frank DeGeorge, Paralyzed Veterans of America. These are friends of ours and we're glad to have them back today.

Your full statements will be put in the record. We would like to move on. As we always have the same problems, we will probably get a vote at 10:00 o'clock, so we would like to move on as quickly as possible. You full statements will be put in the record.

Mr. Magill, go ahead.

STATEMENTS OF JAMES N. MAGILL, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES; DAVID W. GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR FOR MEDICAL AFFAIRS, DISABLED AMERICAN VETERANS; AND FRANK R. DE GEORGE, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

STATEMENT OF JAMES N. MAGILL

Mr. MAGILL. Thank you, Mr. Chairman, for the opportunity to present the views of the Veterans of Foreign Wars. In order to conserve time, I will just mention the bills that enjoy the support of

the VFW, and then go into detail where we have some reservations.

The VFW supports H.R. 2001, 2002, 2003, 2004, 2006, 2007. With respect to H.R. 2010, we have no objections with the bill's provisions authorizing a maximum of two Associate Deputy Medical Directors. We do, however, have strong reservations with the provision which would reduce the number of Assistant Chief Medical Directors.

What is particularly disturbing to the VFW is the fact that H.R. 2010 does not specifically require an Assistant Chief Medical Director for Geriatrics and Extended Care. Considering the vital role geriatric care will be playing in the near future, we cannot understand why the VA would eliminate this crucial position. While, again, the VFW will not oppose H.R. 2010, we cannot stress strongly enough our recommendation that specific language requiring an Assistant Chief Medical Director for Geriatrics and Extended Care be included in H.R. 2010.

H.R. 2146, introduced by Congressman Lane Evans of this committee, would extend the transition period for the Veterans' Administration readjustment counseling centers program. The VFW has long supported the vet center program and we encourage favorable action on this bill. The large numbers of veterans utilizing this valuable program attest to its being extended.

H.R. 2327 would amend title 38 to ensure eligibility for beneficiary travel benefits to certain individuals. This bill was introduced by the ranking minority member of the full committee and enjoys the cosponsorship of over 100 Members of Congress.

The VFW, at our most recent national convention, adopted a resolution addressing this issue. While this resolution, a copy of which is appended to my statement, goes further than what is provided for in H.R. 2327, the VFW nevertheless commends the ranking minority member for introducing this much needed legislation. H.R. 2327 is a step in the right direction and the VFW supports its enactment.

Finally, we were asked to comment on a draft proposal submitted by the chairman of the House Veterans' Affairs Committee intended to improve health care programs of the Veterans' Administration.

The draft legislation before us makes several technical amendments designed to reflect in title 38 recently enacted legislation. The proposal would also allow category A patients to receive outpatient care. The bill would also allow the Veterans' Administration to extend nurses premium pay for an entire weekend; transfer pharmacist pay schedule authority from title V to title 38; grant the Administrator the authority to appoint disciplinary boards; liberalize the VA's health profession scholarship program; and exclude temporary research personnel of the Veterans' Administration from any ceiling on full-time equivalent employees. The VFW supports these legislative initiatives.

Section 9 would establish a pilot program to allow certain VA medical center directors flexibility in the management and administration of their individual medical center. The VFW applauds this attempt to discover new progressive ways of improving VA medical center operations.

Section 10 would give authority to conduct a pilot program aimed at helping homeless veterans who are chronically mentally ill. As you know, the VFW has often testified on behalf of the homeless veteran. The VFW supports this pilot program.

This concludes my statement, Mr. Chairman. I will be happy to respond to any questions you may have.

[The prepared statement of Mr. Magill appears at p. 88.]

Mr. MONTGOMERY. Thank you very much, Mr. Magill.

Mr. Gorman, we will move on to you.

STATEMENT OF DAVID W. GORMAN

Mr. GORMAN. Thank you very much, Mr. Chairman.

I would like to take this opportunity to say how very much the DAV appreciates the opportunity to relate our views on the various legislative items that are included on the hearing agenda this morning.

Mr. Chairman, our written statement relates our views on all of the measures before the subcommittee and I would like to take just these few minutes to discuss those areas of particular interest and concern to the DAV.

Section 2 of the draft legislation has the full support of the DAV. We continue to feel that mandating the VA to furnish outpatient services to eligible veterans is a necessary step toward ensuring that veterans receive the health care services they do require. Likewise, the DAV supports the perceived intent of section 3, clarifying eligibility for receiving domiciliary care. However, we suggest some further refinement of the statutory language so there will be no question regarding the service-connected disabled veteran's eligibility for such care.

The DAV supports sections 5 and 7 of the draft bill which will, in our view, go a long way towards assisting the VA to alleviate some of their recruitment and retention problems; therefore, we fully support those provisions.

Mr. Chairman, so long as the pilot program proposed by section 9 of the draft legislation does not impede the furnishing of medical services to otherwise eligible veterans, we also support this measure.

Section 10 would mandate the Administrator to conduct a pilot program in order to provide care in community-based facilities for homeless veterans. Fiscal year 1988 funding would be authorized at $6 million.

Mr. Chairman, we continue to feel that unused VA facilities, as well as a meaningful expansion of the domiciliary program, provides an excellent opportunity to provide needed services to homeless veterans. However, we also recognize some degree of community involvement must play an important part in this endeavor. Therefore, we have no objection to this provision. We encourage very close monitoring, however, of the program to ensure that the authorized funding level is indeed sufficient and appropriate to adequately address the program.

The DAV supports H.R. 2006 and we are particularly pleased with the proposed amendment to section 624 of title 38 that, in essence, removes the requirement that a United States veteran must

be a citizen of this country in order to receive VA health care benefits. Although not explicitly stated in the language of the bill, this would greatly benefit those individuals who are Canadian citizens but who are also veterans of the United States armed forces and who incurred service-connected disabilities as a result of such service, mostly Vietnam service.

Mr. Chairman, we object to that one section of H.R. 2010 that would remove the statutory requirement that the Assistant Chief Medical Director for Geriatrics must be a physician who was either trained in or possesses extensive experience in the field of geriatric medicine. It is our view that, when considering the range of issues and all the other medical disciplines involved in attempting to meet the unique needs of a rapidly-aging veteran population, a physician with suitable qualifications in geriatrics is the only possible and logical choice to address this pressing issue.

We have no objection to the enactment of H.R. 2146, except we do not favor that portion of the measure that would mandate the Administrator to maintain, until October 1, 1988, the same number of community-based vet centers that were in operation as of April 1, 1987.

Finally, Mr. Chairman, we are pleased to address H.R. 2327 and state our full support of this measure, as introduced by the distinguished ranking minority member of the committee, Mr. Solomon, and yourself. Simply stated, this measure would mandate the Administrator to provide beneficiary travel payments to specifically defined eligiblbe veterans.

Mr. Chairman, in the short span of 5 weeks since the agency has amended their regulations to terminate this benefit, our national service officers across the country, as well as our national headquarters here in Washington, have been besieged with inquiries and complaints by veterans who are extremely concerned about their ability to continue to receive VA health care services if, in fact, they are unable to receive beneficiary travel payments.

To countless veterans, elimination of this benefit is a very real threat. Veterans reliance on these payments is dramatically portrayed in the MAXIMUS study released in early 1985, the highlights of which are related in my written testimony. It is shown that a full 35 percent of the veterans included in that survey, mostly service connected, low income, and frequent users of the system, fear they would be denied access to the VA health care services they deserve if this benefit were eliminated, as it recently has been.

Mr. Chairman, while we fully support this measure, we do make a suggestion in order to maintain the intent of providing VA health care to the most deserving veterans. We suggest a technical amendment to this measure would be warranted to include, in the defined list of eligible veterans, any service-connected veteran who does seek VA health care services.

That concludes my oral remarks, Mr. Chairman. Thank you.

[The prepared statement of Mr. Gorman appears at p. 91.]

Mr. MONTGOMERY. Thank you very much.

Mr. DeGeorge.

STATEMENT OF FRANK R. DE GEORGE

Mr. DEGEORGE. Thank you, Mr. Chairman. PVA appreciates the subcommittee's responsible efforts to conduct this important hearing regarding improvements in related VA health care programs.

Before I proceed with further comments, I would also like to, on behalf of the PVA, congratulate you for your efforts on the passage of the GI bill, a very important piece of legislation. Thank you.

Regarding the VA health care amendments of 1987, this draft bill would amend or repeal certain sections or provisions of title 38, United States Code. We will comment in certain areas that we see as being significant to the PVA membership.

Section 2, eligibility for medical services. This section, as amended, would provide VA outpatient treatment as an entitlement to veterans as defined eligible under category A. PVA endorses the purpose and intent of this amendment.

PVA testified earlier that under current law, category A, certain nonservice-connected veterans may also receive outpatient treatment when it obviates the need for inpatient care, is a follow up to an episode of inpatient care, or, according to the VA, if space is available. There is considerable latitude in the exercise of the VA physician's judgment regarding the interpretation of "to obviate the need" for hospitalization.

The recent marked reduction in VA inpatient census and length of stay is primarily dollar driver, stemming from the imposition of DRG-based resource distribution and decremental budgets. Similarly, it appears that outpatient care to obviate the need for hospital admission is now more restrictively granted. PVA believes from the position of continuity of care, as well as continuity with other Federal health programs, that outpatient services for category A veterans should be made an entitlement.

Indeed, the Congressional Budget Office, in the analysis of the original version of Public Law 99-272, which included full outpatient entitlement, judged it to be a cost-saving legislative proposal.

Section 3, domiciliary care. PVA believes that expanding the eligibility provisions of this program will, in part, address the plight of homeless veterans needing shelter and medical support, assist veterans under category A status, and in the future provide institutional care for certain older veterans.

PVA supports this effort. However, we believe that in order to be consistent with other VA health care eligibility requirements, that veterans with service-connected disability should receive priority for domiciliary care.

Section 5, nurses premium pay. This section is designed to provide VA nurses with weekend premium pay for weekend duty which occurs on a Saturday or Sunday. PVA strongly supports such measures designed to enhance the recruitment and retention of VA nurses.

Section 5(b), pharmacists. This provision adds pharmacists to the title V/title 38 hybrid personnel group. This personnel regrouping will give the VA greater flexibility in hiring practices and settng pay rates for this group of health professionals already identified in the 1986 VA Health Occupational Survey to be experiencing

severe shortages. PVA supports this provision as a necessary retention and recruitment technique.

Section 7 regarding the scholarship program, PVA supports and applauds the efforts of this subcommittee to expand the health professions scholarship program. We have previously testified that not only should this important program be expanded to other critically needed health professions, but that this program should be fully funded this year and also be made permanent.

H.R. 2327 regarding beneficiary travel. PVA recognizes and commends both the Honorable Gerald Solomon, ranking minority member of the House Committee on Veterans' Affairs, and the Honorable G.V. (Sonny) Montgomery, Chairman of the Committee, for their efforts and initiative to introduce this excellent legislation. PVA supports this significant legislation that would restore to a great degree beneficiary travel payments. The bill would restore the benefit to eligible veterans, including certain veterans whose annual income does not exceed the maximum annual rate of pension which would be payable to such veteran if such veteran were eligible for pension.

Finally, Mr. Chairman, and very briefly, I would like to take this opportunity to mention that the Senate, under the leadership of Senator Alan Cranston, has already included a provision to authorize procreative services in S. 6, the "Veterans Health Care Improvement Act of 1987." It is our hope that we will also gain the essential support of this committee on this issue of significant relevance to our membership.

I thank you again, Mr. Chairman, and members of the committee, for holding this hearing. I will be happy to answer any questions you may have.

[The prepared statement of Mr. DeGeorge appears at p. 101.]

Mr. MONTGOMERY. Thank you, Mr. DeGeorge. We always enjoy your testimony. It was very helpful.

I only have one question, and I will direct that at Mr. Gorman of the DAV, but I want to make a statement before the question.

To clarify, I have introduced H.R. 2001, 2002, 2003, 2004, 2005, 2006, 2007 and 2010 at the request of the Veterans' Administration. Your observation, Mr. Gorman, that the VA has the expertise in certain benefit programs and should be encouraged to apply that expertise to the problems of the homeless, rather than necessarily creating new programs, I agree with that.

My question is, is my encouragement for the expansion of the VA's domiciliary program for homeless consistent with your idea?

Mr. GORMAN. Yes, it is, Mr. Chairman. Number one, there have been a number of domiciliary beds closed over the past few years. In our view, it wouldn't take an awful lot of resources or energy to reactivate those beds, which would provide a much needed expansion of the domiciliary program, and perhaps not only for homeless veterans but for all eligible veterans.

Additionally, we think the VA medical center setting itself is a prime example of real benefit to these types of veterans. They will be on medical center grounds, they would have access to any needed medical services, mental health services and the like. Additionally, veterans benefit counselors as well as DAV national service officers, also frequent medical centers on a regular basis and, as

far as benefit counseling, and access to VA disability and other benefits, it would be a really accessible source. For those reasons, and more, we support the expansion of the domiciliary program.

Mr. MONTGOMERY. I was told yesterday by Mrs. Schroeder of Colorado that, in Denver, 60 percent of the homeless out there are veterans. That seems rather high. I guess my point is, a good part of these homeless are veterans with a certain type of problems.

Does anybody want to comment on that?

Mr. GORMAN. Exactly. And whether a disabled veteran or a veteran in need of service is homeless or not, it is our opinion that the veteran should be getting those services.

As you mentioned Denver, in our written testimony we have mentioned, under the discussion of the restoration of some of the beneficiary travel programs, the DAV has instituted our own DAV transportation network across the country. I think Denver is a prime example of the success of the program. In Denver alone, just in April, the DAV was successful and, via transportation by volunteer drivers and DAV-owned vehicles, transported or assisted 600 or so veterans to the VA medical centers and outpatient clinics throughout the State for treatment. It wouldn't surprise me one bit if these homeless veterans that we're talking about need that kind of service, and with the cooperation of the VA, we're trying to provide it to them.

Mr. MONTGOMERY. Thank you. That is good information. That is where the veterans' organizations can certainly step in and help these veterans, help our committee, help our country and help the VA by doing the things you just mentioned.

What I will do is recognize Mr. Hammerschmidt. He seems to have some questions there. Then after that, any other members that have any comments or questions, the Chair will recognize them.

Mr. Hammerschmidt.

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

Mr. Chairman, I have been looking at this discussion draft of May 11, 1987. I am glad that it is just a discussion draft because, after reading from page 2, section 2, eligibility for medical services, and then listening to the testimony of Mr. Magill, Mr. Gorman and Mr. DeGeorge, I am wondering if in this draft we may not be communicating well with the language in here. So let me ask a question to try to clarify what I think our intent is and see what your response is.

You don't necessarily have to respond right now, if you would rather wait and respond for the record. It is important enough that I think you may want to do it that way. But I would ask each one of you individually. Jim, I will start with you.

Are you advocating that all category A veterans be given full outpatient eligibility as a matter of right, or are you advocating only that current law be changed from "may" to "shall" as to current outpatient eligibility? In other words, would you expand, for instance, from the current eligibility, which is, as you know, treatment for service-connected conditions, treatment for all veterans rated 50 percent or more, treatment to obviate the need for inpatient care, and post-hospital care to complete an episode of treatment?

My question is, is that what you support, only you would change it from "may" to "shall"? As I say, you can respond now or later on for the record.

Mr. MAGILL. I believe I would like to take that option, because of the importance of that question, sir, and respond in detail very soon to it, if you would not mind.

Mr. HAMMERSCHMIDT. Fine.

David?

Mr. GORMAN. I would respond in writing, also, Mr. Hammerschmidt, with some supporting documentation that I think is important.

Mr. HAMMERSCHMIDT. Frank?

Mr. DEGEORGE. I agree.

Mr. HAMMERSCHMIDT. I will tell you my concern. If we open this up to the degree that it appears some of your statements suggest—and you may have been misled by this draft—we're getting into a lot of money and something that I don't think the system could afford. I don't think they could physically get the job done and it might cost a quarter of a billion dollars. That's what worries me. So I think that is an area that we really need to have you on record about what your position is, and maybe have some interim discussion in the meantime about that. So I would appreciate your later responses on that.

[The written responses appear at p. 115.]

Mr. HAMMERSCHMIDT. David, let me ask you, what number of veterans have used your transportation network?

Mr. GORMAN. Mr. Hammerschmidt, the DAV Transportation Program has been in the works, conceptually only since December of 1986. With the assistance of the Veterans' Administration, particularly Dr. Gronvall's office and the office of Sam Piper, we were able to put together an agreement between the DAV and the Veterans' Administration. At that point, which was probably about the beginning of March, we then had to go out and establish it organizationally.

I think the only real figures and statistics we have come from the State of Colorado. I can surely provide those for the record. But briefly, they show that—

Mr. HAMMERSCHMIDT. No, just providing them for the record would be fine.

Mr. GORMAN. Okay.

Mr. HAMMERSCHMIDT. Anything you want to give verbally is all right, but we would like it for the record.

[The information appears at p. 99.]

Mr. GORMAN. Again, this is the only State that so far has responded with statistics. In our opinion, they were very impressive. The program is proving successful in that area and I am sure it will across the country.

Mr. HAMMERSCHMIDT. One more question to the DAV.

You state on page 5 of your testimony, with respect to a pilot program on homeless veterans, that you have no serious objections to it. Are you saying that you favor more use of unused current VA buildings as a better solution to this problem?

Mr. GORMAN. Exactly.

Mr. HAMMERSCHMIDT. Thank you very much.

Thank you, Mr. Chairman.

Mr. MONTGOMERY. Do any other members have any comments? Let me get to Mr. Staggers there.

Mr. STAGGERS. Mr. Chairman, I haven't had a chance to congratulate you on the GI bill. When I was growing up and playing football in Keyser, WV, I used to come off the field and see the pleasure in my father's face. He had a lot to do with me playing football, but I am the one who carried the ball. You and Mr. Solomon have carried the ball, and if you would have seen my face yesterday, I think you would have seen the same type of pleasure. I congratulate you on your efforts.

Mr. MONTGOMERY. Thank you.

Mr. STAGGERS. I do have one comment. I would congratulate my friend and colleague, Mr. Evans, on his leadership on the vets storefront centers. I know in your written testimony there was some comments about it.

Could each one of you give your positions about the 1-year extension and on the potential closing or possible closings of the vet storefront centers?

Mr. MAGILL. The Veterans of Foreign Wars enthusiastically supports the extension for 1 year of the vet center program.

Mr. STAGGERS. I'm glad to hear that.

Mr. GORMAN. Also, Mr. Staggers, the DAV supports the extension.

Mr. DEGEORGE. The Paralyzed Veterans of America definitely supports the full bill as written, to include the tabling of the closing of the nine vet centers, and we thank Mr. Evans for his submission of the bill as well.

Mr. STAGGERS. I appreciate that and I commend my colleague, Mr. Evans.

Thank you, Mr. Chairman.

Mr. MONTGOMERY. Thank you, Harley.

The ranking minority member, Gerry Solomon.

Mr. SOLOMON. Thank you, Mr. Chairman.

First of all, I just want to tell the DAV that we really appreciate the efforts you have done in the absence of the beneficiairy travel coverage that we have now and your picking up the slack. I know it creates a burden on you and you really shouldn't have to do that. But I am sure the veterans appreciate it, and I know they do in my district, which is a rural district and hard to get around in.

I also want to just take the time and thank all of you for the support that you gave to H.R. 2327. You know, it is obvious, with 177-some sponsors now on the legislation, that your organizations and some that will testify later on were out there really pushing it. It has made quite a difference. So it is a concerted effort and we appreciate it and feel it will work out good.

Thank you.

Mr. MONTGOMERY. Let me go to Roy. He's on the committee.

Dr. ROWLAND of Georgia. No questions, Mr. Chairman.

Mr. MONTGOMERY. Okay. Lane?

Mr. EVANS. Mr. Chairman, just very quickly, I want to thank the three organizations and their representatives for supporting the legislation I have offered, as well as some of the other issues before us.

Thank you.

Mr. MONTGOMERY. Any other members? The gentleman from Florida.

Mr. BILIRAKIS. Mr. Chairman, thank you. I have a very brief opening statement that I would ask unanimous consent to be put in the record.

Mr. MONTGOMERY. Without objection, so ordered.

[The prepared statement of Congressman Bilirakis appears at p. 116.]

Mr. BILIRAKIS. I would just hitchhike on to that, sir, by first of all congratulating you for sort of flipflopping the agenda, if you will, where we used to always hear from the VA first and then from the veterans organizations. I think this makes an awful lot more sense, sir, and I certainly commend you for that.

Mr. MONTGOMERY. Also, I have noticed in the audience that the Veterans' Administration is here, so they get to hear the other witnesses.

Mr. BILIRAKIS. Exactly.

Mr. MONTGOMERY. I appreciate your being here. I know you would rather be doing other things, but thank you for being here and listening to our witnesses. Then we will hear from you.

Mr. BILIRAKIS. Generally, they have usually waited. Even though they have testified in past hearings, they have always waited in the audience—

Mr. MONTGOMERY. Sometimes they didn't.

[Laughter.]

Mr. BILIRAKIS. That's why I said "generally", Mr. Chairman. But now they can actually comment and respond to what they hear from the veterans organizations, which I think makes sense.

I would also like to commend you, sir, for your apparent emphasis on outpatient care. I know we have had an awful lot of testimony over the years to the effect that this is exploding on us, the need for care, and particularly in Florida, with all the very senior veterans population. The only way that I think we're ever going to be able to handle this is through outpatient care and through clinics. So I would certainly support the emphasis on outpatient care.

Thank you, Mr. Chairman.

Mr. MONTGOMERY. There is no question about it. I would hope the members of the committee would go out and look at these outpatient clinics and the veterans hospitals. I think we're going to have to look more to sharing agreements. If you're fortunate enough to have a military hospital near you, then we ought to work on sharing agreements between the military hospitals and the veterans hospitals. We can give better care not only to our veterans but also can help the military patients. So it has a lot of merit to it and we definitely should try to push in that area.

Do any other members have any comments?

John Rowland.

Mr. ROWLAND of Connecticut. Mr. Chairman, I would just like to add that I think all of us on the committee have read various articles over the past year about VA hospitals, not only in our districts and in our States, but across the Nation, having problems and dealing with morale problems and attitude problems. I think the actions we're taking today and by working together, both with the

veterans organizations and the VA themselves and among ourselves together, I think we're going to address some of these concerns this year and try to correct some of the attitudes about the VA hospitals and the quality of care. I am just very pleased to be a part of this effort, and I want to commend you and thank all of my colleagues for what has happened in the past couple of months.

I would also note to the VA that the chairman duly notes when any witnesses leave, as well as when the Members leave, and we're all kept in line.

Mr. MONTGOMERY. Thank you.

To follow up on what you said, John Rowland, I am having some complaints in my own State pertaining to VA medical care. It's not only the VA. I think any professional type of work, whether civilian, military, county or city, you have these problems.

But what I am picking up is in the hospitals the ward attendants, the people who work in the outpatient clinics, they have got to be more polite to people. They have got to have a little better attitude. When these veterans come into these outpatient clinics, when they come into the veterans hospitals, they are nervous anyway. They're concerned. They wouldn't be there if they didn't have some physical problem.

To follow up on what you said, if we could get across to them to be more polite to these veterans—you know, we think we can find people to take the places of these staff people who maybe are getting tired of their job. They're good jobs and we can find other people to come in. But I find that generally, with our medical care, I get less complaints on medical care in the VA hospitals. It is just kind of the attitude that hits these people when they come in. You get them all up tight and you have a problem there.

Mr. HAMMERSCHMIDT. Would the chairman yield?

Mr. MONTGOMERY. Yes.

Mr. HAMMERSCHMIDT. I just want to comment that in Arkansas, to use that as an example, we have three hospitals there, two in Little Rock and one in Fayetteville. My experience is that the quality of care there is very good and very appreciated by the veterans. We have high quality staff and they really couldn't operate without the great volunteer service of these service organizations, their auxiliaries, and a lot of times the members themselves.

But then we read a GAO report that is out today—and not that we shouldn't look into it, and not that it doesn't create concern, but when you consider that there are about a million and a half patients that go in and out of these hospitals every year, and about 18 million outpatient visits, I think when they dwell on one or two or a half-a-dozen cases and put it in the paper, then it gives the general perception that is way out of proportion to the actual services being rendered. I just think we ought to know that, by and large, we have an excellent health care delivery system in the VA.

Thank you, Mr. Chairman.

Dr. ROWLAND of Georgia. Mr. Chairman.

Mr. SOLOMON. Would the gentleman yield further?

Mr. MONTGOMERY. Let me get Dr. Rowland first.

Dr. ROWLAND of Georgia. I just want to follow up on what you said, Mr. Chairman, about the perception that a veteran patient has when he comes in.

I know that over the years that I practiced medicine there were many times that someone came to see me and I thought their problem was insignificant. It wasn't insignificant to them, though. They wouldn't have been there if it was not a very trying situation for them. So what I tried to do always was to keep that in mind and make them feel comfortable and make them feel like I was just as much interested in their problem, although it might not have seemed so severe to me.

I think that's what you're talking about and I think that's the feeling that has to be given to people. They have to be made to feel that their problem is a problem that is serious and they came seeking help and not to be treated in a trivial manner. I think that is so important. I think many times people who deal with patients forget that when they are first seen.

Mr. MONTGOMERY. Well said. I know that after you have seen 25 or 30 people that morning you get impatient. It's just a problem that needs some correction.

Mr. Solomon.

Mr. SOLOMON. Mr. Chairman, I just wanted to follow up on the same subject. You know, these kinds of reports are kind of demoralizing to people who work and do such a good job in the veterans hospitals around the country. I know in my district I have far less complaints from the veterans hospital than I do from public and private sector hospitals. Of course, you don't see too much in the paper about such complaints because they are not about a Federal Government agency. We do have to be extremely concerned and we do have to fund properly the veterans hospitals if we're going to get and improve the medical care that we have.

But we also have to be careful not to be too critical of those that we have. I know in Albany, NY, that that hospital is outstanding. They do such a great job. They need to have their morale lifted up a little bit. So I think we have to praise them as well as make sure they're doing the job, too.

Mr. BILIRAKIS. Mr. Chairman.

Mr. MONTGOMERY. Yes, sir.

Mr. BILIRAKIS. Sir, I would like to sort of endorse all the remarks. I know that in our two hospitals in our area, neither or which are in my district but are in the Tampa Bay area—I think Mr. Solomon said it well. I think we get more complaints regarding the private and public hospitals as far as medical care is concerned.

But your point in terms of attitude is a good one. We have had hearing after hearing—Roy and I had one down there—and it seems to be attitude. It seems there are some employees of the Veterans' Administration that look at caring for veterans as welfare. Well, by gosh, it's the furthest point from that. With that kind of an attitude, obviously, the Veterans' Administration should never have hired them, nor should they retain an employee who is proven to have that sort of an attitude. So you do run into that, the lack of politeness and so on. But as far as medical care is concerned, I certainly endorse the remarks of Mr. Hammerschmidt and Mr. Solomon.

Mr. DEGEORGE. Mr. Chairman, if you will allow me, I think this is what is important about your recruitment and retention portions of the legislation here today. That, in itself, will certainly help

morale, recognizing people working on Saturday and Sundays, providing incentives for that. I just had to add that.

Thank you.

Mr. MONTGOMERY. Thank you very much. We appreciate this panel and would now ask panel number two to come forward.

I might say that as far as employees are concerned, we might be offering some constructive criticisms, but you don't have a better friend than this Veterans' Affairs Committee. We have always tried to protect the veterans employees and we stood up for them. You get a lot of rumors started out there, which most of them aren't true. Your best friends are in this committee room today. But attitudes need to be improved, as far as I'm concerned. I'm sending out consultants and they're coming in and saying that some of these employees' attitudes are not good. They lose patience with the patients, and that shouldn't happen.

We now have Mary Stout, National Secretary of the Vietnam Veterans of America, accompanied by Mike Leaveck, Director of Legislative Affairs, and Richard Weidman, Director of Government Relations. Also, Mr. Paul Egan, The American Legion, and Mr. Kirk is with him.

Mary, I called you first, so why don't you start.

STATEMENTS OF MARY STOUT, NATIONAL SECRETARY, VIETNAM VETERANS OF AMERICA; ACCOMPANIED BY MICHAEL R. LEAVECK, DIRECTOR OF LEGISLATIVE AFFAIRS, AND RICHARD F. WEIDMAN, DIRECTOR OF GOVERNMENT RELATIONS, VIETNAM VETERANS OF AMERICA; PAUL S. EGAN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION, AND RODNEY S. KIRK, ASSISTANT DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

STATEMENT OF MARY STOUT

Ms. STOUT. Thank you, Mr. Chairman.

I would also like to take the opportunity along with everyone here to congratulate you on the passage of the GI bill, which we were involved in that and very pleased. It was through your leadership, I don't think anyone can deny, that the GI bill has passed and is helping the young people of our military service.

Mr. MONTGOMERY. Mary, like I said yesterday, of those 38 members that were there, each one of them individually did something to help us pass this legislation. You have to go talk to them, go talk to the Senators. They made suggestions. So, with the different veterans organizations, it was a total team effort. As I said also yesterday, that was as good a lobbying group as has ever been put together on Capital Hill. I'll just about take on any of them now. I found that out.

Ms. STOUT. Yes. We were very pleased to be a part of that, too.

I want to thank you for giving Vietnam Veterans of America the opportunity to present our views regarding the issues before you. You asked us to comment on a number of legislative proposals, each of which is important. However, I shall confine my remarks to H.R. 2146, for it is our belief that the Veterans' Administration is engaged in a reckless rush to eliminate the veterans outreach cen-

ters by any means necessary. Vietnam Veterans of America urges the quickest possible passage of this legislation to avoid irreparable damge to veterans in need of assistance.

H.R. 2146 contains two basic provisions. First is a 1-year delay in the beginning of the transition period. The second simply closes a loophole that allows the Veterans' Administrator to begin the relocation of the outreach centers without the consent of Congress. It is unfortunate that this provision is necessary because the intent of Congress is clear. The commencement of the transition period is set by Congress, not the VA.

We firmly believe the overwhelming evidence of need warrants the continuation of the delivery of readjustment counseling services by means of the 188 community-based veterans outreach centers.

We also beleive a review of the chronology of the extra-legal pilot program to close the nine community-based outreach centers, contained as an appendix to our written statement, clearly shows an effort to eliminate the entire outreach center program in disregard for and in violation of the intent of Congress.

The Centers for Disease Control study, entitled "Post-Service Mortality Among Vietnam Veterans", reveals a mortality rate among Vietnam theater veterans 45 percent higher than that for era veterans from external causes, a category which includes suicides, homicides, motor vehicle accidents and drug overdoses.

In the past 10 years, deaths due to external causes have declined. We believe the decline is due in large part to the increased availability of intervention and counseling services, most notably, the veteran outreach centers.

The best measure of need, however, is the actual number of veterans who seek services from the veterans outreach centers. The number of new clients seen, the number of total patient visits, and the total number of veterans seen has risen almost every year. The veterans outreach centers have been examined by the Congress, by the press, and by numerous internal mechanisms of the Veterans' Administration. In every case, the conclusion has been that the need for these services is a major one and that the unique community-based nature of the veterans outreach centers is the most efficient and cost-effective way of reaching the veterans most in need of assistance.

Mr. Chairman, two very important studies regarding the continuing need and effectiveness of these centers should be used in assessing the future of the program. The GAO report requested by the chairman of the Senate Committee on Veterans' Affairs, to examine specific aspects of the Readjustment Counseling Program, has not yet been released. The National Vietnam Veterans Readjustment Study by Research Triangle Institute is not expected to reach its final conclusions until September, 1988. And yet, the VA is closing these community centers.

Mr. Chairman, the VA has maintained that the so-called pilot program of closing outreach centers is not arbitrary. It is a well-conceived, deliberate process and really just a judicious management exercise. The chronology presented in our written statement should make it clear that this was, in fact, a rush to begin the total elimination of the community-based sites and not based on the best

medical judgment. Medical professionals and others cautioned the Administrator's staff that this process was proceeding too quickly and that mistakes may have been made in targeting. My own phone survey of the nine vet center team leaders indicated that there was no consultation with them when the list was prepared. There was no consultation with veterans service organizations in the affected communities. All team leaders expressed a commitment to continue to do the best possible job for their clients and to project these moves in a positive light, even if they personally felt that the move to the VAMC would be detrimental to their existing clients and to their outreach efforts.

The passage of H.R. 2146 will mandate, in the letter of the law, what has always been the intent of this law, that readjustment counseling services be delivered in community-based, veterans outreach centers, separate and apart from the VA medical centers, unless Congress mandates otherwise. Unfortunately, in light of the flaunting of the letter of the law, of Public Law 99–156, passage of H.R. 2146 may have to be only the first step. Rigorous oversight and vigilence of the committee may be necessary to prevent the political structure within the VA from subverting the clinical aims of the veterans outreach centers.

We wish to impress on this committee the urgency of this legislation, as the Administrator of the VA has already begun the process of closure. In fact, the Wilimgton, DE veterans outreach center has closed as of May 1 of this year. Expeditious passage of H.R. 2146 is, in our view, critical if Congress is to have the opportunity to accomplish the assessment as it has mandated and make the decisions about the future of this program.

The Vietnam Veterans of America thanks you, Mr. Chairman, for the opportunity to present our views on this issue of vital importance to Vietnam veterans. As always, we admire and appreciate your leadership on this and other issues.

Thank you.

[The prepared statement of Ms. Stout appears at p. 117.]

Mr. MONTGOMERY. Thank you very much, Mary.

At this time the Chair will call for a recess to go vote, which should take 10 minutes. I would ask that the witnesses remain and that Dr. Rowland take the chair after we come back.

We will be in recess for 10 minutes.

[Whereupon, the subcommittee was in recess.]

Mr. ROWLAND OF GEORGIA [Presiding]. We would like to get started and ask that the witnesses return to the table, please.

We will now hear from Mr. Egan. Proceed in your own manner.

STATEMENT OF PAUL S. EGAN

Mr. EGAN. Thank you very much, Mr. Chairman. Rod Kirk, the Assistant Director of our Veterans Affairs and Rehabilitation Commission, will summarize for us. However, I would like to make just as couple of comments on two of the bills under consideration today.

First of all, the bill introduced by Mr. Solomon, The American Legion certainly supports that. It represents, in our judgment, a long-overdue solution to a problem that has been rather nettle-

some. It would make beneficiary travel an entitlement for the identified categories of veterans in the bill. It takes this entire issue out of the realm of discretionary spending and takes an important step forward in assuring that this critically important benefit is available to those people who most need it.

The other bill is Mr. Evans' bill, regarding the vet center program. We certainly support that. We think, consistent with Mr. Hammerschmidt's opening statement, it may be possible for some of these vet centers to be co-located with VA medical centers, but also consistent with Mr. Hammerschmidt's opening remarks, we think that this ought to be based on medical judgment. From what we understand from what is going on within the VA, that is not the case. If what we have been told is true, VA made up its mind as to what nine particular vet centers were going to be amalgamated into VA medical centers within a 72-hour period.

As we saw last week in the hearing by the Oversight and Investigations Subcommittee, on the colocation of VA regional offices with VA medical centers, it has taken them months and months and months to arrive at just five that could be colocated, but only 72 hours to do the nine vet centers. That doesn't seem to us to be consistent either with good basic judgment or with good medical judgment.

After having said that, I will turn the microphone over to Mr. Kirk.

Dr. ROWLAND of Georgia. Thank you very much.

Mr. Kirk.

STATEMENT OF RODNEY S. KIRK

Mr. KIRK. Thank you, Mr. Chairman, and members of the subcommittee. The American Legion certainly appreciates this opportunity to present its views on the several proposals relating to the veterans' health care that are under consideration here today.

H.R. 2001 would extend the adult day health care program and authorize contract halfway house care for veterans with chronic psychiatric disabilities. The American Legion has consistently supported the theory of maintaining the veteran patient in the community as much as and for as long as possible. These adult day health care programs, oftentimes a direct alternative to nursing home care, provide a one-stop service to veteran patients for nursing needs, nutritional services, social services, rehabilitation requirements, medical management, and socialization. The American Legion has stated on a number of occasions during hearings before this subcommittee that it is our intent to encourage both Congress and the VA to foster the development and implementation of all the innovative techniques that can be used to both make the system more cost effective and able to care for the largest number of patients. The adult day health care program is such a technique and we strongly support the extension proposed in this bill.

Also included within this bill is a section to authorize contract halfway house care to veterans with chronic psychiatric disabilities. Again, for the reasons previously cited, The American Legion supports this proposal.

H.R. 2006 would amend section 603(a) of the title to provide the Veterans' Administration with the authority to pay for emergency hospital care for veterans who have been placed in community nursing homes at VA expense. The American Legion is supportive of this provision.

The third provision set forth in H.R. 2006 would amend section 624(b) of the title to provide service-connected veterans who are foreign nationals residing abroad with eligibility for VA health care for their service-incurred disabilities. This change would primarily benefit a group of Canadian citizens who were disabled while serving in the U.S. forces during Vietnam. The American Legion urges the enactment of this proposal.

H.R. 2146 would amend 612(a) of the title to extend the transition period during which time the provision of readjustment counseling services were to be shifted from storefront operations to existing VA facilities. The American Legion strongly supports this provision, which we are mandated to support through Resolution No. 548, approved by delegates to our 1986 national convention.

H.R. 2327 provides specific statutory authority versus the current discretionary authority for reimbursement of beneficiary travel expense for six specific categories of veterans. As Mr. Egan mentioned, The American Legion supports this measure, which would make the beneficiary travel program an entitlement.

The last proposal we will address is the discussion draft, titled "The Veterans' Administration Health Care Amendments of 1987." Section 9 of that draft proposes a pilot program on hospital management efficiency. The purpose is to determine the effect of additional authority on the efficiency and economy of the management of five VA medical centers. Under the program, the director of a designated VA medical center may waive or alter such laws and regulations applicable to the management of the facility to improve efficiency and economy. Budget support would be maintained for the period, regardless of any improved efficiency or economy of operation.

The American Legion foresees the potential in such a pilot program and, if enacted, we will review with interest the final report submitted to Congress by the Administrator, as required by this section.

Mr. Chairman, that completes our statement. We will be happy to respond to any questions.

[The prepared statement of the American Legion appears at p. 139.]

Dr. ROWLAND of Georgia. Thank you very much.

Mr. Solomon.

Mr. SOLOMON. Mr. Chairman, I don't really have any questions. Both organizations have been concise in their testimony and we really appreciate that.

Concerning the beneficiary travel legislation, I might just point out to the VVA that we have a particular concern with beneficiary travel for Vietnam veterans. The new regulations, in my opinion, have hurt them, particularly those low income, what you might call the "down and out" people in large areas like New York City.

During the debate over how we would develop this legislation, one way would have been to leave everyone qualified the way they

were and set up a radius of, say, 10 or 15 miles, or 25 miles. If we did that, that would probably hurt Vietnam veterans more than anybody else. So when we came up with the proposed bill the way we did, that was one of the major concerns. We would appreciate later on your comment or your help in that direction because we want to do what is fair and what is affordable under the present fiscal restraints that we have. We don't want to be forced into going back to a situation of developing some kind of a radius which really is going to knock out some needy people. So I just throw that out for your consideration.

Ms. STOUT. Mr. Solomon, we very aware of the problems involved there and are very anxious to work with you and the minority staff on this issue.

Mr. SOLOMON. I appreciate that very much.

I don't have any further questions, Mr. Chairman.

Dr. ROWLAND of Georgia. Thank you, Mr. Solomon.

Mr. Evans.

Mr. EVANS. Thank you, Mr. Chairman.

Mr. Egan, I also share your frustraton with the issue of the colocation of these vet centers compared to the colocation of the regional offices. It is very ironic that when there is no organized opposition, no opposition from veterans' organizations to the colocation of the regional offices, we see the VA and perhaps OMB dragging their feet; but when there is basically opposition to closing these vet centers, at least in lieu of the study, that we see the VA rushing ahead.

I guess I would just ask, what is your particular concerns regarding the nine vet centers, why do you think we should at least hold off closing them for the time being while—

Mr. EGAN. As I understand it, at least six of them do not comply with the very criteria that the VA has established for making a determination as to which ones might appropriately be amalgamated into VA medical centers.

What is truly ironic about all of this, Mr. Evans, is that in the case of the colocation of regional offices, as well as the colocation of vet centers, in both instances the veteran loses. If you set a criteria based on what benefits veterans, in the case of the regional offices, more colocation is better; in the case of vet centers, at least as far as these nine are concerned, colocation is bad, and yet we're moving willy-nilly forward with doing it. It doesn't make any sense.

Mr. EVANS. Mary Stout, or the VVA panel, are you familiar with the Wilmington, DE center that has been closed and where it has been relocated?

Ms. STOUT. Yes. I have been in contact with the vet centers as they have been going through this process, particularly those nine. I spoke with the team leader yesterday and we have also been in contact with our chapter.

That particular vet center was moved into one of the old residences on the campus of the medical center. We understand it's like a four-bedroom house. When I first talked to the team, they were enthusiastic about the move; they thought it would still have a very homey atmosphere and that people would be comfortable there. They were concerned about the travel of those inner-city people who were using the vet center facility in Wilmington. To

date, only one of what they call the "street people", the homeless people who normally came by for services, has been able to make it out to the medical center. They are seeing a lot more VA medical center employees coming to the vet center who never came downtown.

One of the problems in the move is that they are located on the hospital grounds behind the hospital in a residence. Our understanding is that when you drive back to go to that vet center, there is a big sign on the street that says "do not enter—residents only." So those who may not have called beforehand to find out that they should ignore the sign really can't find the vet center there right now.

Mr. EVANS. That's disturbing to me because, basically, the idea behind the vet center program itself is to deal with some of the alienation that particularly Vietnam veterans face and some of the bureaucracy that they more or less resist. If it is not located in an area that is accessible, particularly to the lower income veternas, or once they get there they have these kinds of signs which indicate that people aren't welcome, I would believe that would put off a great deal of the potential clientele.

In your written statement you outlined what you term a tale of two pilots. Why do you call the pilot program to close nine community-based outreach centers the "extra-legal" pilot project?

Ms. STOUT. I think the legislation, as written, indicated that these were to be community-based outreach centers. The tale of two pilots is really about how quickly the Veterans' Administration was able to make a determination to begin the movement of nine outreach centers before the transition period, which was supposed to start this October. These are all lined up to go or to be well on the road to being moved before that transition date begins.

The other pilot program, which was mandated by Congress, is the establishment of the Vietnam veterans resource centers. It has taken 17 months to get two of them opened up and there are eight more that haven't been established yet.

Mr. EVANS. Why do you feel the Administrator's office is so determined to close outreach centers?

Ms. STOUT. I think there are a lot of political ramifications to Vietnam veterans in this society. If we close the vet centers and move all of those off the street who are getting services, who are looking for services, we can say everybody is well. It is a matter of control.

Those independently established vet centers do work in the community. The Veterans' Administration wants to keep everything very tight, centrally located, and centrally directed. These are a move out of that kind of program.

We also think that, in the long range, when you're trying to establish whether we should be look at whether we can go to war again, if you haven't completely finished taking care of the last warriors, it may be difficult to convince the country that we can do that.

Mr. EVANS. Thank you, Mr. Chairman.

Dr. ROWLAND of Georgia. Thank you, Mr. Evans.

Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Well, I would first like to thank our panel for their interest in coming here today and giving us their input. I think you would all agree, as with all the veterans groups in the audience, that all of this legislation is an indication of the responsiveness of this committee to veterans' needs. I know I serve on Energy and Commerce and others of us serve on other committees, and we can all say, without any hesitation, that no committee moves the way the Veterans' Affairs Committee does when there is a need for legislation. That is principally because we work on a bipartisan basis—or maybe I should say a nonpartisan basis—with services to veterans being the only objective.

Congressman Hammerschmidt, the gentleman from Arkansas, asked a question about the outpatient services. I guess he covered this—I had just come in then and I'm not really sure. But basically, the category A, which is now an all-encompassing group, did you understand his question and the input that was required from the previous panel—which I would suggest we would also like to hear from this panel—was he asking you for a subcategory group in terms of priorities within category A? Was that basically his question?

We're going to ask for the same input from these good people then, too, are we not, for the record? Because the previous panel is going to give us input, I would ask unanimous consent that this particular group also be added to that so you can give us your input.

Dr. ROWLAND of Georgia. Without objection.

[The written responses appear on p. 172.]

Mr. EGAN. Mr. Bilirakis, as I understood Mr. Hammerschmidt's question, it was whether or not we interpreted the provision of the draft bill to mean that, in effect, the "shall/may" controversy was going to be resolved, or whether or not the language in the draft bill meant something far beyond that, considerably more expensive.

Mr. BILIRAKIS. Yes, that is sort of what I caught from his question, too. So I would like to maybe expand on that, if I may, and ask you if there has to be any prioritizing— and it almost seems like maybe there should be within category A, assuming that this legislation passes and maybe is cleared up in terms of some of the areas where it is still in draft form. Obviously, if you could maybe help us out in terms of what you think those priorities should be.

Mr. EGAN. As far as The American Legion is concerned, there was never any question about the intent of the original legislation establishing a means test, and that was that category A veterans would be entitled to treatment. To the extent the language of the draft bill solves that disagreement over the intent of the original legislation, we certainly support it.

As to whether or not we would concur with interpreting that language to be broader, I'm afraid we would have to take a little longer look at it. To give you a more accurate response, we would have to respond for the record.

Mr. BILIRAKIS. Okay. So basically we're saying the categories of priority that are set up, as far as hospitalization is concerned, would be the same priority that would exist in outpatient care? I raise that question maybe to my colleagues.

Dr. ROWLAND of Georgia. I will have some comments that I'm going to make later to the Veterans' Administration regarding outpatient care.

Mr. BILIRAKIS. Okay. We'll defer that.

Thank you, Mr. Chairman.

Dr. ROWLAND of Georgia. Thank you, Mr. Bilirakis.

Mr. Kennedy.

Mr. KENNEDY. Thank you, Dr. Rowland.

Since serving on this committee for the last few months, it seems there has been continuous tension, particularly between some of the Vietnam era veterans and the VA. I have visited on a number of occasions the vet center that is very close to my home in Brighton, MA that serves a population of individuals that are obviously struggling with just the day-to-day holes in terms of society.

It just would seem to me that here we have a situation where the VA was asked to do a study to determine the effectiveness of having these centers in the VA system and where the hospitals are. I have talked with the head of the VA hospital in Brockton who was supposed to, in fact, take in the vet center in Avon, MA. He said point blank that the people who depend on the vet center just won't come into a hospital. I can't imagine people at the Brighton center going down to St. Elizabeth's or any of the Veterans' Administration facilities. The kind of problems they're facing are not the problems that you want to go to a hospital to deal with.

I don't know if you would want to comment a little bit about what the basic fundamental purpose of those centers are and why you don't feel the VA is somehow sensitive to the needs of veterans that are, in fact, using those services.

Ms. STOUT. Do you want to comment, Rick?

Mr. WEIDMAN. It is not that the VA's Department of Medicine and Surgery is not sensitive or has become insensitive since 1979 to the special needs of many—not all, but many Vietnam veterans who will not use VA medical center facilities. If left to their own devices, the Department of Medicine and Surgery structures, working from the ground up, from the vet center planning committee to the policy advisory board, to then the Chief Medical Director, through the Deputy Chief Medical Director—at that time, Dr. Gronvall—to the Chief Medical Director, who more than a year ago was set and poised to recommend to the Administrator to seek extension of this program and do away with the so-called "drop dead" date, Mr. Kennedy, that whole process stopped last spring, when under orders from—during the transition. We have come back to the situation that we're in now.

Mr. KENNEDY. When you say under orders, does that mean you have to place someone under orders to stop that?

Mr. WEIDMAN. The recommendation was never taken up and basically was put on the shelf by the new Administrator and the current Administrtor, General Thomas K. Turnage. So the process stopped.

The point I'm trying to get out is that within the Department of Medicine and Surgery it was recognized there was a unique place in the matrix of delivery of medical care to veterans for the community-based, Vietnam veterans outreach centers, or veteran outreach centers. Frankly, there are a lot of Korean and World War II

vets who will not to go a hospital for psychological services because, first, they're afraid of getting put on medication, and secondly, psychologically, they don't want to admit that they're ill. They will go and seek those services if it takes place in a nonthreatening atmosphere.

Mr. KENNEDY. I couldn't agree with you more. But the question is why do we want to shut these centers down?

Mr. EGAN. May I respond to that?

Mr. KENNEDY. Sure.

Mr. EGAN. I think there is a legitimate question that is being asked within the VA, and the question is, how long after the war is over do we need to address ourselves to readjustment problems, whether those be psychological problems, educational problems, employment problems, or whatever other kind of problems. That debate goes on within the VA. We believe, as I believe VVA believes, that psychological readjustment problems still exist, they are still residual from the Vietnam war, and they still need to be addressed by the vet center program.

Unfortunately, there is a rather nasty side to the debate over at the VA, where some people believe that we don't need readjustment counseling for Vietnam veterans any longer, that what we really need is counseling for a mid-life crisis. So it really becomes very ugly over at the VA in terms of the debate between the people who are the clinical professionals and the people who are in the political hierarchy. That is where the debate is and that's what the problem is.

Mr. KENNEDY. I appreciate your answer, Mr. Egan.

I would just turn to Mr. Evans for a second and wonder whether or not this is a debate that maybe this committee ought to be involved with as well as the VA and the various veterans organizations, because it seems like a lot of these issues end up being devisive as a result of not having that issue resolved.

Mr. EVANS. If I may just have some time, I think the gentleman is correct. I think that is what we're trying to do and inject ourselves into this debate.

I would agree with Mr. Egan. Of course, there is some residual feeling within the VA that these centers should never have been opened and, therefore, since they should never have been opened, they perhaps should now be closed. I thought we dealt with that problem many years ago, even before I came to Congress, but I think there is some of that still left in the VA. Maybe Mr. Egan would have a response.

Mr. EGAN. I just want to underline the importance of the fact that there is a legitimate policy question here about readjustment benefits. I think the clinical professionals— and certainly the veterans organizations agree—that there is an ongoing, currently needed, and for the foreseeable future will be needed, psychological readjustment benefits for Vietnam veterans, and the vet centers uniquely perform that service.

Mr. EVANS. Mr. Weidman?

I know I'm overstepping my time, which I guess is Mr. Kennedy's time.

Mr. KENNEDY. It's not my time. I have finished.

Dr. ROWLAND of Georgia. As long as the gentleman from Massachusetts wants to yield to the gentleman from Illinois.

Mr. KENNEDY. Yes.

Mr. EVANS. Mr. Weidman?

Mr. WEIDMAN. I just wanted to come back and clarify one last thing, Mr. Kennedy, in regard to the thrust of your question.

The best medical judgment, which Mr. Hammerschmidt spoke about this morning, in the case of extra-legal pilot programs, the best medical judgment never came into play. The process was already well down the line to shifting from "are there centers where we can move and still be effective" to "I want nine targets and I want those things eliminated and on my desk within 10 days." That order came from someone in the political power structure, who is not trained nor has he ever served as a medical practitioner. The Chief Medical Director only certified the process less than 72 hours before the final presentation and rendering unto the nine target sites. That is the point that we're bringing up.

It is a preservation of the best medical judgment and experience of those highly dedicated folks who work under Dr. Gronvall and Dr. Gronvall himself that we are striving to make sure that they can do their job without interference from the political power structure, whether that be located on the tenth floor of the VA or across the street at OMB and the White House.

Mr. EVANS. Mr. Chairman, I just want to associate myself with the remarks of Congressman Kennedy. I have never been to Brighton, but this is the same kind of situation I have seen in Watts and in the south side of Chicago, in Moline, IL as well, veteran centers across the country that I have been to. I think you will find a real reluctance of veterans from the Vietnam era going into the hospital system itself, particularly if there are signs saying "do not enter" once they get there. So I think you're absolutely right in your analysis of the situation and the feeling of the Vietnam veterans that I have met. I appreciate your remarks.

Thank you, Mr. Chairman.

Dr. ROWLAND of Georgia. Thank you very much.

I want to thank the witnesses at the table very much for being here today. We do appreciate it.

Dr. ROWLAND of Georgia. The next panel is Dr. John Gronvall, Chief Medical Director of the Veterans' Administration, with his entourage. Dr. Gronvall, thank you for being here, and all of those who accompany you. You may proceed as you so desire.

STATEMENT OF JOHN A. GRONVALL, M.D., CHIEF MEDICAL DIRECTOR, VETERANS' ADMINISTRATION; ACCOMPANIED BY VERNICE FERGUSON, DEPUTY ASSISTANT CHIEF MEDICAL DIRECTOR FOR NURSING; MICHAEL RUDD, DIRECTOR, OFFICE OF PERSONNEL AND LABOR RELATIONS; ROBERT LINDSEY, DIRECTOR, OFFICE OF OPERATIONS; MICHAEL M. LAWSON, DIRECTOR, MEDICAL ADMINISTRATION SERVICE; AND DONALD L. IVERS, ESQ., GENERAL COUNSEL, VETERANS' ADMINISTRATION

Dr. GRONVALL. Thank you very much, Mr. Chairman.

Let me first introduce those members of the VA staff who are with me here at the table. On my far left is Mr. Michael Rudd, who heads our personnel system. Immediately next to me is Mr. Mike Lawson, who is in our Medical Administration Service. To my immediate right is Vernice Ferguson, who heads the nursing program for the VA. To her right is Mr. Bob Lindsey, who is our Director of Operations. And on my far right is Mr. Don Ivers, the General Counsel of the VA.

We have submitted to the committee a long report and statement which details our comments on each of the legislative proposals before the committee today. I am sure it will be introduced to the record and I can, in the interest of time, just make a summary statement.

Dr. ROWLAND of Georgia. Without objection.

Dr. GRONVALL. Thank you very much.

The first thing I want to say is to thank the chairman of this committee for introducing many of the legislative proposals that the VA had asked to be submitted for legislative consideration.

Going on to a number of items, then, we are particularly pleased that the chairman has reintroduced the proposal to authorize the pilot project on hospital management efficiency. As we had testified previously, we continue to be convinced that this project will be able to show that we can make significant productivity improvements if we are able to decentralize authority and remove many of the unnecessary constraints on our medical center directors.

In the list of proposals before the committee today, let me just mention proposals that we support, and then I can go on to other matters. We support the proposed modification of domiciliary care eligibility. We support the procedural improvements in the disciplinary process for title 38 employees. We support expansion of the Health Professions Scholarship Program to include the additional categories of health occupations, and we support in concept the continuation of the contract community halfway house programs for homeless veterans.

Let me comment on the vet center transition issue. We support the proposed legislation which would delay the required transition period, but we do not support the part of H.R. 2146 that would require us to freeze in place all of the free-standing counseling centers. We believe the relocation plan that the VA developed for nine vet centers this year is a logical first step that will allow us to study the implications of a physical relocation of the vet center to the medical center campus. Both existing law and the proposed law that I have just referred to, in fact, mandate that that transition be made. We believe that in preparation for that transition a more limited relocation is an appropriate first step.

Moving on to the matter of outpatient care, we do not support the proposed legisltion having to do with outpatient eligibility at this time. The proposal, as written, would provide a mandate for comprehensive outpatient care to all veterans that are eligibile for mandatory hospital care, or so-called category A eligible veterans.

At the present time, our outpatient eligibility statute gives highest priority for care to service-connected veterans, then to a number of special category veterans, and then, following that, to the extent that we have the capacity, to nonservice connected, low-

income veterans. The bill as presently drafted would mandate comprehensive outpatient services to all category A veterans.

A major revision of eligibility for veterans care, of course, has just recently been enacted and begun in actual implementation in July, 1986. It appears to us that more time is necessary of the impact of this major revision in eligibility reform before enacting another revision in eligibility. In short, we believe that an assessment should be made of the impact of the revised eligibility to identify whether, in fact, there is a specific problem in regard to outpatient care and, if so, what the character of that problem is, what its dimensions are, what the cost implications are, and how best to solve the problem that would be so identified.

Let me comment on beneficiary travel. Mr. Chairman, we also do not support the proposed change in the rules governing beneficiary travel as proposed in H.R. 2327. Once again, we have just recently adopted new regulations and rules and implemented those to restructure the beneficiary travel program, and it is our view that an evaluation of the impact of this revision should be made before a legislative change is made in that program.

In addition, there is a major private sector VSO initiative that has been described here, the DAV transportation network. We, like the DAV, have a number of anecdotal reports about the actual impact of the changes and the extent to which that voluntary cooperation between the VA and the DAV is assisting in this regard. We believe that that should be further evaluated before legislation is enacted.

Finally, Mr. Chairman, we did testify at the hearing here on April 22 that we are experiencing significant difficulties in maintaining an adequate staff in a number of occupations in some particular locations throughout the country. At that hearing, we outlined a number of efforts underway to attempt to alleviate these problems. The initiatives that we described included emphasis, and a new acceleration and use of our special salary rate program, the identification of additional funds for tuition assistance this year, and the scholarship program which will be established in fiscal 1988.

We commented also that a departmental task force is intensively reviewing this entire situation and is scheduled shortly to produce a comprehensive set of recommendtions to address all of these problems. As a result, at the present time, while we compliment the committee for seeking to help us address these problems, we are not prepared at this moment to support a number of the initiatives that have been proposed and are on the agenda today. While recognizing and appreciating the importance attached to this by the committee, our desire is to devote some more time, receive our task force report, and work further with the committee on steps that may need to be done to produce the best possible solution to these problems.

In summary, again, our full statement responds to and describes all of the matters before the committee today. I would again repeat that we very much appreciate the opportunity to appear before the committee, to hear the other testimony that's been given, and I and my colleagues will be pleased now to respond to any questions that you or the committee members may have.

Thank you.

[The prepared statement of Dr. Gronvall appears at p. 145.]

Dr. ROWLAND of Georgia. Thank you very much, Dr. Gronvall.

Does anyone else at the table plan to make a statement at this point?

Dr. GRONVALL. No.

Dr. ROWLAND of Georgia. One issue that I want to raise, that we were talking about a few minutes ago, is outpatient care. As you know, in the private sector there is a move now—and has been for the past several years—to address patient needs more on an outpatient basis rather than in the hospital. In fact, there are many empty hospital beds around the country now because of this very thing. One of the reasons for that, of course, is that it's less expensive to treat people on an outpatient basis for many of the things they were treated for in hospitals in the past.

I can recall, when I was practicing medicine in the early years, that hospitalization insurance didn't provide for outpatient care. Consequently, when someone came in that needed to have a procedure done, you put them in the hospital to do it, which turned out to be much more expensive than if it were done on an outpatient basis. Eventually the insurance companies recognized that and moved to put outpatient care in their insurance policies.

With respect to the categories of patients that are treated, if someone comes to the hospital outpatient department to be treated and they don't fit into that particular category and would be eligible for outpatient care, it seems to me that the person would need to be examined to determine whether or not they were, in fact, sick enough to be put in the hospital. You have got to make that determination. I don't think you can just turn people away because they don't fit that category. So it seems to me that the perception of not looking at that patient certainly doesn't serve the VA very well. And if you do examine that person and find out they don't need hospitalization, then not giving them the medication that they might need does again create a bad perception. The patient says well, they examined me, but they didn't give me anything for it because they said I was not eligible for outpatient treatment.

So it seems to me that possibly in the long run, from the standpoint of perception and from the standpoint of actual cost savings to the VA, that maybe your objection to outpatient treatment may not be as valid as it would seem to be on its face. I would like for you to respond to that, if you will.

Dr. GRONVALL. Let me state immediately that we totally agree with all of the introductory comments you made about the importance of outpatient care and the appropriateness of doing things in the outpatient setting rather than in the hospital and we are working to do that. Our comments on this bill have nothing to do with resistance to the idea of providing diagnosis and treatment in the outpatient setting when that is possible.

Also, I want to emphasize that in every case where a veteran applies for medical care, an examination is done and a medical judgment is made as to what kind of care is necessary. The eligibility criteria, the means test for eligibility, comes in only after a medical judgment is made about the need for care, and conditions as to whether the VA directly provides the care or refers the veteran

somewhere else if the veteran is not eligible for the particular kind of care that is needed.

Again, in every instance where a veteran and, for that matter, a nonveteran appears at a VA medical center in urgent need of care, we provide the care regardless of the eligibility status, and then let the eligibility and paperwork catch up with the case after the fact.

Back to this present instance, we do have defined eligibility requirements now for provision of outpatient care, and we utilize those requirements. Over the past years our outpatient program has been expanding rapidly, while at the same time the number of acute hospital beds that we're operating has declined as a reflection of that, and as a reflection of shortened length of stay. So we are doing exactly what you describe.

Our concern on this particular bill is that, as I said, we have just made a major revision in eligibility and that new statute is being implemented. We are not aware, because the assessment has really not been conducted, of whether there is a problem with regard to outpatient care. We have heard, and I have heard, some anecdotal reports, but I have not had any specific instance referred to me by name and with specific dates where a veteran has been inappropriately turned away from receiving care that's needed.

So our posture on the legislation is that that kind of assessment should be done. While supporting the kind of outpatient care programs you describe, we want to be certain we have identified a problem and, if so, what it is, and the costs and other implications to correct the problem. When the veteran needs outpatient care that he or she is not eligible to receive in the VA, our social work service and our community referral programs assist in referring the veteran to community health resources that can deliver the care. So we do not turn our backs on a veteran who needs medical care.

Dr. ROWLAND of Georgia. I see my time has expired.

I do recall two veterans that told me that they were examined and then referred to private physicians. They didn't have a very good feeling about that.

Since my time has expired, I will pursue this a little bit further when I come back around to myself.

Mr. Solomon.

Mr. SOLOMON. Thank you, Mr. Chairman.

First let me praise you, Dr. Gronvall, and all of your people with you, for the usual, sincere and conscientious effort that you make. I appreciate it and I'm sure all the veterans do, too.

Dr. GRONVALL. Thank you.

Mr. SOLOMON. Having said that, let me mildly flog you a little bit for mildly opposing my beneficiary travel bill.

[Laughter.]

I say mildly because I have a feeling that perhaps in your conversations with OMB that you sort of stuck up for Gerry Solomon a little bit. I understand what happens there.

You were in the audience, I think, when I made my opening statements—

Dr. GRONVALL. Yes, sir.

Mr. SOLOMON. —and I know that OMB puts pressure on everybody for across-the-board cuts for everybody's programs. It doesn't

matter whether it's veterans benefits or social programs or what it is. I know it is hard for OMB to back off, and it is hard for the man I worship, President Reagan, to back off from saying we've got to deal with those deficits. So I understand the pressures that you are under.

Nevertheless, as I said before, we are going to, in my opinion, lay a bill on the President's desk, because the Senate and the House will agree. Therefore, we need your input on this beneficiary travel. Never mind what OMB wants you to say. We want you to sit down and work with us because we want a bill on the President's desk that he will sign. That is why we can't just carte blanche say we'll restore everything that we had before. We don't want to, on the other hand, put something there that is not going to be fair and affordable. So we do have to work together, and I know I can count on you to do that, in trying to carve out a bill that might be better than even what we have here. I happen to think this is a good bill.

Having said all that, let me get to a couple of questions before my time runs out.

Do you have any plans at all to eliminate all of the veteran centers or to relocate all of them to VA medical centers? How do you respond to charges of this nature? Let's just get it on the record once and for all. Do you intend to close them all or do you intend to move them all to hospital settings? What do you intend to do? What is the intent of the VA?

Dr. GRONVALL. I would be pleased to answer that, and I appreciate the question.

We have no intent to close all of the vet centers or eliminate them. The law that is now on the books and the proposed revision of that statute mandates a transition that would require that a majority of the vet centers, rather than operate on a free-standing basis, operate on the medical center grounds in collaboration with our medical centers. It was on that basis that we began in the Department of Medicine and Surgery, some time ago, to prepare for that by discussing and developing criteria for a pilot relocation effort, considering individual sites where that relocation could be most expeditiously carried out.

The decision to relocate the nine centers in advance of the time that the law specifically mandated that transition was believed by us to be a responsible action within the authority of the VA, to gain some experience in the relocations, see what the impact on the programs would be, and assist us in planning for a large scale transition mandated by law.

In regard to the nine, just one other comment. The relocation of those nine is a physical relocation of the site of delivery of the vet center mission only. No other change is contemplated in the vet centers. The same staff will be carrying out the vet center program. The mission will be the same. The operating budget is unaffected and the line responsibility through the Readjustment Counseling Program is unaltered by this physical relocation of the site of carrying out the mission.

Mr. SOLOMON. I guess that's speaking for the political side, Joe, which you were getting at, or Lane.

What about the best medical judgment? Can you also speak to that point, as far as this transition program is concerned? What is the best medical judgment of the VA, for the record?

Dr. GRONVALL. I would be very pleased to, because we have tried hard, I think, to have that best judgment expressed.

I think there is no doubt that the vet center program has served an extraordinarily useful purpose. In my own view, the fact that the Nation failed to assist veterans returning from Vietnam in reentering the mainstream of American life has been ameliorated to a significant extent by the vet center program.

Our own long-term projections have been, as was suggested here earlier, that, over time, the readjustment mission will be completed. Our vet center people have made various projections that they would predict the utilization of the vet centers would begin to decline predictably as the mission was accomplished, and our own recommendations have been that the program should be reduced only on the basis of its declining utilization to accomplish the purpose it was originally set up to accomplish.

I think there is a significant body of professional opinion within the VA that, as time progresses, having the vet center program operate on the grounds of a medical center separate from the main hospital operation, in closer collaboration with the medical center staff, can bring benefit to the program by having additional resources from other staff in the medical center who are more immediately available to assist veterans who need assistance of a medical nature along with the counseling by the vet center staff.

Mr. SOLOMON. You have just stated, I guess, the best medical judgment. That best medical judgment statement you just made for the record, is that supported by the political hierarchy at the VA?

Dr. GRONVALL. I think you're asking me to, in a sense, speak for other people. I have not had that expression expressly disagreed with by anyone in a responsible position in the VA.

Much issue has been made here today, understandably, about the timetable in which we were beginning to take those steps in preparing for a transition. But I am not aware of a decision, a mandate, an action, that has been taken by the leadership of the Veterans' Administration that is obverse to what I have just said.

Mr. SOLOMON. My time is up, but I will ask you to go back to the political hierarchy and let them say to us in writing that they support that medical statement. I support what you said and I would like to hear them support it as well. Then we have no problem between the best medical judgment and the best political judgment of the VA. I think it will clarify a lot of things.

Dr. GRONVALL. Thank you.

[Subsequently, the Veterans' Administration furnished the following:]

The Administrator is forwarding a letter to Mr. Solomon and Chairman Montgomery corroborating Dr. Gronvall's testimony regarding the pilot program to relocate nine Vet Centers on VA Medical Center grounds.

Mr. SOLOMON. Thank you, Mr. Chairman. I didn't mean to take so much time.

Dr. ROWLAND of Georgia. Thank you, Mr. Solomon.

Mr. Kennedy.

Mr. KENNEDY. Thank you, Mr. Chairman.

I think that goes right to the heart of it, Mr. Solomon. I appreciate it.

Dr. Gronvall, I understood at the beginning of your answer to the first question you stated you were acting in accordance with the law. And yet, as I understand the law, it says that you're only supposed to start shutting down those centers once the reports have been filed. Yet the reports have not been filed. Therefore, there is this period between October 1, 1987, when there are no reports filed, and May, 1987, when, in fact, you have gone and begun shutting these centers down. So that would indicate there was a certain willingness on the part of the VA to ignore whatever the medical or political consensus might be and just go right ahead and shut the centers down.

Secondly, you mentioned that you felt these centers were going to, in fact, be located on hospital grounds but outside the hospital. The one specific case that I know of, in talking with the director of the VA hospital in Brockton, he said that basically he would look around and see if he could find four desks for the counselors within the building, but he had no site that he had in mind certainly.

Thirdly, as I understand it, it took 17 months for the VA to comply with Public Law 99-166 to set up the program, but it took 17 days to shut them down. So one would get the impression that there is a certain insensitivity or a certain willingness on the part of the VA to see these centers shut down and perhaps not be as concerned as you and Mr. Solomon have indicated to the needs of the Vietnam veterans.

Dr. GRONVALL. Let me make a couple of comments, Mr. Kennedy, to your question, and then I will ask Mr. Ivers to comment also on the legal issue that you raise.

First, I would say we have not taken or proposed any steps to shut down any vet center—

Mr. KENNEDY. Maybe I misspoke by saying shut down, but to move them into the hospitals.

Dr. GRONVALL. I think that taking an activity and physically relocating it from one location to another location, while preserving the entire staff, the same budget, the same mission and the same management or programmatic line of responsibility, is really quite different than shutting down the program. So that has not been proposed.

Mr. KENNEDY. Just so we're in synch here, I misspoke if I said shutting down. So let's take shutting down off the table and let's talk about moving them into the hospital.

What we're suggesting is the congressional intent in the law was to have the purpose of those centers reviewed before any decision was made to change their physical location. Therefore, what I am trying to find out is whether or not you actually went through the process of finding out whether or not it was needed or whether or not it was just some accountant's decision to shut them down.

Dr. GRONVALL. You are quite right, of course, that the reports described in the existing statute have not been submitted to the Congress.

I would like to ask Mr. Ivers to comment on the law because my understanding of the existing law is that there is not, in fact, a mandate in the law to operate the vet center program entirely as a

set of free-standing or community-based programs and that, in fact, the decision about the location of individual vet centers prior to the transition is within the authority of the VA.

Mr. Ivers?

Mr. KENNEDY. It might be within the authority of the VA. It's a question of whether or not you're following congressional intent.

Dr. GRONVALL. Whenever the question of congressional intent is raised, I turn to the General Counsel to tell me what the congressional intent is, because I think they interpret for us the law and the intent of the Congress. So really, all I'm asking is for Mr. Ivers to comment on that question.

Mr. KENNEDY. I hope our counsel is loaded up here, too.

[Laughter.]

Mr. IVERS. Mr. Kennedy, we feel we are complying with the intent of Congress in the projected relocation of nine of these vet centers to VA medical center facilities. Granted, this is prior to the filing or submission of the report. However, the statute calls for an orderly transition to begin taking place at a specific time. We believe that in this process, these nine vet centers are merely a small sample to help us prepare for that orderly transition. That is the intent with which we entered it and the spirit with which we entered into this process.

There is no prohibition, as I see it, in the statute on the Administrator's taking this action. There is no intent on the part of the Administrator or anyone else in the VA, to my knowledge, as has been said here, to eliminate the vet center program or shut down the vet center program. That's not an issue with us, either. The idea is to make a determination as to how these services can be best delivered and how the intent of Congress to have the VA conduct an orderly transition can be best carried out.

Mr. KENNEDY. It just seems, as I understand it, that the intent of Congress was for us to make those determinations, not for you to make those determinations.

Mr. IVERS. Well, obviously, we disagree on that particular point. But I will let it go at that.

Mr. KENNEDY. Thank you.

Dr. ROWLAND of Georgia. Thank you, Mr Kennedy.

Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Dr. Gronvall, good morning.

Dr. GRONVALL. Good morning.

Mr. BILIRAKIS. Sir, are we agreed that, in general, outpatient care is less expensive than inpatient care?

Dr. GRONVALL. Absolutely.

Mr. BILIRAKIS. And are we agreed—and former Administrator Harry Walters used to make these comments often, and I know you have heard them, too—that considering the anticipated explosion of medical care for veterans, probably the way to go is going to be outpatient clinics, outpatient care, to be able to service more veterans, and probably more efficiently and at less cost.

Dr. GRONVALL. Absolutely. One of my principal goals within the VA which I have had people working on is to accelerate the expansion of our outpatient care capability and look for ways that we

can accomplsih, in an outpatient setting, things that now we require hospitalization to carry out. Absolutely.

Mr. BILIRAKIS. Thank you.

Now, should a category A veteran, category A as per the recent law—which would include the low-income people as well as service-connected, et cetera—if that person should not go to a full-fledged hospital, medical center, but instead go to an outpatient clinic, whether it be free-standing or part of the medical center, but still outpatient services, would the costs in servicing that patient on an outpatient basis be any more than they would be than if he entered the hospital?

Dr. GRONVALL. No. If the same care could be delivered in an outpatient setting, it is more economical to do that than to put the patient in the hospital.

Mr. BILIRAKIS. If we're talking about outpatient care versus inpatient care, or in-hospital care, and if we're talking about the category that officially you don't feel—and I'm not sure that you don't feel that way—but basically, officially, in your capacity as Chief Medical Director, that if that person now has to go into the hospital for a certain type of care and he qualifies because of the low-income guidelines, let's say, but for that same care he would not qualify on an outpatient basis, how is it we're saving money by virtue of saying that that person should be excluded from outpatient care?

Dr. GRONVALL. Under the existing statute that establishes eligibility and priority for outpatient care, a category A veteran is, in fact, eligible for outpatient care if the medical judgment is made that outpatient care could obviate the need for an episode of hospital care.

Mr. BILIRAKIS. Well, you said that earlier. But I'm trying to follow a step-by-step scenario here.

If this person is not now under the law eligible for outpatient care, because he doesn't fall into any of those particular categories, but still qualifies for category A because of low income, below that threshold, that person is not even going to be seen as far as outpatient care is concerned. That patient is not being seen now in the outpatient medical clinic. So who is going to make that determintion at that point in time? He is going to actually have to go into the hospital under the statute and they, in turn, maybe would make that determination and what, send him to outpatient care?

Dr. GRONVALL. The sequence of events you described is not the way that works. When a veteran comes to us, either at a hospital or at a clinic, and applies for care, the veteran says "I'm sick and I need care." A medical evaluation is made in every case. A physician examines the patient and then makes a medical decision about what kind of care is needed.

If the veteran falls in category A and the medical judgment is that hospital care is required, then the veteran is hospitalized. That's very clear. If the physician's determination with regard to a category A veteran is that the veteran has a serious medical problem that needs treatment but that it can be treated on an outpatient basis, and the outpatient care delivered would prevent the need for an episode of hospital care, under the existing rules now

in effect, that veteran has clear eligibility and can be cared for on an outpatient basis.

As we interpret the proposed piece of legislation, the change would require that comprehensive and total outpatient care be given or mandated to every category A veteran for any kind of medical condition, regardless of whether that care was necessary to obviate the need for an episode of hospital care.

Mr. BILIRAKIS. The way I interpret it is that the only type of care that would be available under the new legislation to that particular individual would be outpatient-type care, the type of care that an outpatient clinic now affords. I mean, even for the top category A people, the 100 percent disabled or whatever the case may be, if they were to go to an outpatient clinic now and they qualify, there is only a certain degree of care that they can receive at that outpatient clinic. That doctor would make the decision that they cannot afford care above and beyond that limited by facilities, limited by equipment, limited by the type of medical personnel that are available. But they still qualify to go in there in the first place.

But I'm talking about the person who would not qualify. I'm talking about that low-income person who, under the present law, does not qualify for outpatient care because they're at category A but they're not in the upper reaches, if you will. I guess I'm setting priorities here in my own mind when I say upper reaches versus lower. They're in the category of disabled veteran, you know, over 50 percent, et cetera.

Dr. GRONVALL. Correct.

Mr. BILIRAKIS. My time is certainly up, but it is just not clear in my mind. If my premise is true, that person is not going to be served.

I think if you and I were together and walked into the Fort Richey, FL outpatient clinic with a veteran who doesn't fall within those disability guidelines, but he does fall into category A by virtue of the income threshold, you would see that that person would not be cared for because he doesn't qualify. I'm just wondering, if he doesn't qualify for outpatient care there, he doesn't qualify for outpatient care at the hospital, then he is going to have to go into full care at the medical center, which is a heck of a lot more expensive when, in fact, the outpatient care at that clinic may have been able to take care of him for a lot less cost and probably a lot more efficiently.

[The requested material appears on p. 154.]

Dr. GRONVALL. If I may make a comment, Mr. Chairman, on Mr. Bilirakis' question, there was some earlier discussion about the meaning of the legislation as now drafted. Our understanding of it, is that in the case of any category A veteran who came to the VA, whether he or she came to either the hospital or the clinic, and a medical determination was made that the veteran needed medical care that could be delivered on an ambulatory basis, there would be a requirement that VA provide, in essence, open-ended, comprehensive outpatient medical care for any condition judged by a physician to require medical care to the extent of available facilities and resources. It was that interpretation of the draft statute that led to the question about cost.

Mr. BILIRAKIS. If that veteran, sir, were to go to the medical center and not go to an outpatient facility, you would have that decision to make anyhow. Either you provide for his care there or you farm him out, whatever the case may be.

So are we saying it's going to cost a heck of a lot more under the new law because we think, since it's going to be so inconvenient for the veteran to have to travel to a medical center, that he is not likely to do it and, therefore, we're going to save dollars on that?

Well, I have taken up so much more of my time. I apologize to Mr. Penny and whoever's time I have taken, Mr. Chairman. I don't quite understand this. I think I understand the law as it's drafted.

Dr. ROWLAND of Georgia. We will come back to that.

Mr. Penny?

Dr. GRONVALL. I would be pleased to comment further.

Mr. PENNY. Thank you, Mr. Chairman.

I have an observation to make on two of the provisions in the package of bills that we are considering.

First of all, I am pleased to see the recommendation for increased authority on the part of the local medical director. I think that some cost savings can be achieved by giving that authority to the director and then have that savings rolled back into medical care. I am glad to know the VA supports that, as I know most veterans groups do.

I am also very supportive of Mr. Solomon's proposal to restore some kind of transportation allowance for many of our veterans who need that assistance in order to access VA health care.

I want to yield my remaining 4 minutes to Mr. Lane Evans, who I know has additional questions of this panel.

Mr. EVANS. Mr. Chairman, I am not a member of this subcommittee and I have a number of questions. It might be better if I could wait until the other subcommittee members are done.

Dr. ROWLAND of Georgia. Suppose you proceed, Mr. Evans, and then we can come back to the others.

Mr. EVANS. Thank you.

Dr. Gronvall, we want to thank you for waiting. I know you do this as a matter of regular course anyway, but thank you for waiting and responding as our last panel.

I did submit to you, along with Congressman Johnson, a letter—I think it was dated April 22—and we asked that you respond in 15 days. We haven't received a response yet. Rather than ask you those questions, I would just ask if you could give me as quick a response as possible on that letter concerning the specific legislation in front of us.

Dr. GRONVALL. I apologize that we haven't gotten an answer to you. I don't recollect the specific letter, but I will today look into it and assure you that we'll get you an answer as quickly as we possibly can. I apologize.

Mr. EVANS. I know we keep you busy before this committee and others, so I am sure it's an oversight.

The Senate has considered legislation very similar to what I have introduced, what we are deliberating over in today's hearing, and I have a list of the nine centers with the proposed target dates, knowing already that the Wilmington, DE center has been relocated already. I guess our concern is, given the fact that we expect

action on this bill, I guess we're looking for the VA to understand that. I know that complicated legal issues are involved in the termination of leases or the renewal of leases and so forth.

I guess my concern is what happens, where are we in the process, given the fact that some of these centers are scheduled—including the Oak Park, IL center which is to be closed this month. If this legislation passes, particularly if we reinstate with specific language in the bill or in report language that these centers be reopened, if that does, in fact, happen, won't the VA have to undo what they've already done? I guessd I'm asking for some forebearance while we consider and deliberate over this legisltion.

Can you tell us what you might be doing in that interim?

Dr. GRONVALL. Well, as has been described, a decision was made some time ago to take the step of relocating the nine centers. Our readjustment counseling staff and our medical center operating staff got together and developed an implementation plan for each of those nine. Each one, of course, is an individual case having to do with leases, available space at the medical center, the appropriate timetable, et cetera. All of that has been in motion.

You're quite right that the one in Wilmington has already been relocated. Again, if a law passed which rolled back those decisions or mandated a different decision, I would, of course, look to the legal staff of the VA to ensure that we acted consistent with the law. If that meant going back and reopening some vet centers in the community setting, where it had already been relocated and where the leased had terminated, we would take that step. Clearly, if the law mandates that, that would be the step we would take.

Mr. EVANS. There have been a lot of questions here about congressional intent. In light of Congress' decision to begin the transition period on October 1, 1987, after certain reports were issued regarding the transition, do you really feel the VA is acting in accordance with congressional intent by beginning the transition period on May 1, 1987?

Dr. GRONVALL. I believe that we have been. Mr. Ivers has made that comment and he makes it with a base of legal status. All the deliberation that I'm aware of in the Congress, as reflected either in the existing law or the proposed revisions, either here or in the Senate, have all envisioned a transition period at the end of which more than half of the vet centers, in fact, would have been relocated to medical center sites. Since that transition has never been at issue, our view has been that it was responsible, in fact, to gain some experience with relocation of a small number of vet centers to learn how that works and what the impact on the program is. We believe we were acting responsibly to get prepared for the transition that is mandated both by existing law and in any of the legislative proposals that are being deliberated.

Mr. EVANS. Since there is some question of congressional intent here—and perhaps we could lift the burden from your shoulders, if that's what my legislation is calling for, if that's the way you interpret it. Perhaps it would be better if we looked at the requirement for the transition totally.

What would be your response to eliminating the transition requriement in total in current law?

Dr. GRONVALL. I think that would surely be a major rethinking of the vet center program that I would not be prepared to respond to just sitting here. I think we would need to know why that major rethinking had gone on. We would be pleased to work with the committee if that degree of rethinking of the whole mission is going to go on.

I would have to get expert advice from the vet center staff and our medical center staff as to what that would mean and how we ought to operate the program.

Mr. EVANS. Mr. Ivers, you might be able to help clear up I guess some hearsay testimony submitted to this committee about a conversation held on Friday, February 13, between you and General Turnage. According to testimony received—and it is hearsay—General Turnage asked the VA General Counsel, yourself, if he had authority to do so prior to the beginning of the congressionally-approved transition period.

Is that true, or did that happen, that conversation? If it did, are you familiar with the conversation and what was your response?

Mr. IVERS. Mr. Evans, a conversation did occur on that date in that meeting between myself and General Turnage. Over the past couple of months I have become quite accustomed to being misquoted and misrepresented by certain people and certain organizations connected with this issue and others, so I was not at all surprised to see that in the testimony of Vietnam Veterans of America.

A conversation with respect to the vet centers did occur during that meeting, which was, in fact, an internal budget briefing for the Administrator before presenting his testimony here. Whoever provided that information to the Vietnam Veterans of America clearly misquoted me and clearly misstated it and clearly took it out of context.

The discussion was toward whether or not I felt, as a legal issue, we could embark on this relocation initiative at that time. My opinion was, and continues to be, yes. The mandate that is stated in the law is that the Administrator is to provide the services that are provided by the vet centers primarily in free-standing locations. The key to my response was that, in my opinion, we could begin that transition if we wished, given all the other factors that have to be factored in which are not part of my expertise.

Mr. EVANS. I can certainly understand that that's not part of your expertise, but I do have to note, Mr. Ivers, that it's interesting to me that this was at a meeting held about budgetary issues and that this issue came up concerning the Administrator's testimony about the budget.

Could you say that the Administrator's interest in closing the centers was motivated primarily by the budgetary concerns that he was going to have to testify about before this committee?

Mr. IVERS. I couldn't state that at all. In fact, I believe the earlier testimony by Dr. Gronvall and others would put to rest that position. There is no significant budgetary impact inherent in these relocations.

Dr. GRONVALL. Mr. Evans, if I may respond.

Mr. EVANS. I'm over my time and I would like to give you the opportunity. But I am not a subcommittee member and I would

rather defer to the chairman and come back and let you make your statement. I do have a few other questions.

Dr. GRONVALL. I would be pleased to comment specifically on that meeting and the discussion.

Mr. EVANS. Thank you.

Dr. ROWLAND of Georgia. Mr. Rowland.

Mr. ROWLAND of Connecticut. Thank you, Mr. Chairman.

First of all, my apologies, Dr. Gronvall, for missing your testimony, but I have had an opportunity to look over your prepared remarks. I just have one question referring to the pilot program on the hospital management efficiency.

Have you gotten feedback from the local VA medical centers? Have any volunteered or wanted to get involved with the pilot program specifically? Has it been good feedback, bad feedback? I don't know if you've answered this question already or not.

Dr. GRONVALL. That is easy to answer. There is virtually a stampede of medical center directors anxious to have the opportunity to show that, if we give them the tools and hold them accountable, they can run a good medical center and provide good care and find ways to do it more effectively and efficiently.

Mr. ROWLAND of Connecticut. So it is safe to say there is a great deal of interest in the prospect of getting rid of some of the bureaucracy and some of the red tape.

Dr. GRONVALL. Absolutely.

Mr. ROWLAND of Connecticut. How many will you be able to use as pilot programs? Perhaps that was stated in your testimony.

Dr. GRONVALL. Well, the proposal described in the legislation would be a pilot test in which we would select five medical centers. We have done a good deal of thinking about criteria for picking five that would make it the most valid pilot test. So it would be a carefully monitored pilot effort, carried out in five medical centers.

Mr. ROWLAND of Connecticut. Is there going to be any way that you can expand that, or are you going to have to stick with the five? Isn't the reporting time something like 5 years?

Dr. GRONVALL. I don't recall the detail. I don't think it's that long.

Mr. ROWLAND of Connecticut. The time is not important. What I hope is that you will be able to record the information and perhaps, working together, we can move forward with some of the feedback and some of the good information that will come from that program.

Dr. GRONVALL. If I may make a comment to that, this would be a major undertaking. The assessment of whether the experiment is working or not is not easy. You can get a lot of anecdotal information. But to really document that quality was preserved, that care followed the eligibility requirements, was done in a more effective and efficient way, and had long-term benefits is a major investment that takes some time.

I think that if the experiment proceeds, we would certainly look for any early evidence of steps that might hopefully or helpfully be made at other medical centers, to try to benefit from it as it was going along. But I think a full assessment would probably take the 3-year period. I believe the proposal is for a 3-year operation and evaluation period.

Mr. ROWLAND of Connecticut. Thank you very much. Those are all the questions I had. I am glad to see there is some interest there and possibly, in our lifetime, we will be able to make things better for everyone. I appreciate that very much.

Dr. GRONVALL. I certainly hope so.

Mr. ROWLAND of Connecticut. Thank you, Mr. Chairman.

Dr. ROWLAND of Georgia. Thank you, Mr. Rowland.

We are jumping back and forth from one subject to another here. I want to go back to the outpatient treatment.

I feel in my own mind that it would be a savings for the VA to provide outpatient treatment to all veterans, vis-a-vis what we are now doing. And let me give you one example, which is a real example.

A veteran who may not be eligible for outpatient care, a diabetic, for example, develops a respiratory infection, knows he is not eligible, won't come in, and he gets sicker and sicker and eventually does come in with acidosis and has to be put in the hospital. It's a very expensive course of treatment that takes place there. I have seen this happen before so it's not just a theoretical thing.

Let me ask you this. How many veterans do you think are turned away each month by the VA who are not eligible for outpatient treatment?

Dr. GRONVALL. We make those reports, of course, on a monthly basis to the committee staff. I don't have one of those figures right at my hand, but we have been reporting that, on the average, 100 or so veterans each month, after applying for care and being evaluated, cannot receive the care because the particular medical center doesn't have the resources or the clinic or the appropriate care to deliver.

Dr. ROWLAND of Georgia. I was just talking with counsel here. I have been given a figure of about 10,000 maybe all together, across the board, that may be turned away.

Dr. GRONVALL. Ten-thousand per month?

Dr. ROWLAND of Georgia. Yes, sir.

Dr. GRONVALL. I would surely appreciate a chance to follow up with the committee staff to be sure that we are aware of the source of that figure and compare it to the reports we have been submitting. I would be pleased to do that.

[See p. 155.]

Dr. ROWLAND of Georgia. All right.

I think we may be looking at the same situation of perception that we have of entry level personnel. Although the medical care is very good, entry level personnel give a very bad appearance of the VA. I think this outpatient issue may operate in somewhat the same way on that. While the care is real good, those veterans that are turned away get a bad perception, spread this word around, and it does give the VA a bad name.

I am not going to follow up any further on the outpatient issue. I think I have made my feelings pretty well known about that. Mr. Bilirakis might have some more questions on that.

I want to talk just a moment or two and ask your opinion on the nursing shortage, the LPNs and RNs that we have. I have a printout that shows that we do have in a large number of our hospitals a rather severe shortage of RNs and LPNs. In looking for some

way to address that, I think there is the possibility of incentive pay and a trigger in that area when you have a certain percentage of a shortage in order to improve the nursing personnel situation.

Do you feel that maybe a ten percent trigger is too high or too low? Do you understand what I'm saying when I say ten percent? Let me give you an example. If we had a hospital that floored 100 nurses and they had only 89 nurses, that would mean they had vacancies for 11 nurses. So this would be a place where we would trigger incentive pay.

What is your feeling about incentive pay in the areas of shortages?

Dr. GRONVALL. We have authority to grant special pay and we have done it at many of our medical centers. It has made a significant contribution to improving our recruitment and retention situation. So we are totally supportive of being able to make those special pay agreements and have done so.

The specific question you ask about identifying a percentage shortfall in the employed staff and using that as an automatic trigger is an idea that I haven't thought of or heard discussed. I would make a general response that I am anxious to look for anything that will work and make a contribution and then give it full consideration. If the judgment is that it would help, we would want to use it. So I react positively in that general way to any suggestion.

Perhaps Mr. Lindsey or Miss Ferguson could comment more specifically on that.

Mr. LINDSEY. I might add just one thing, that if we find we have a high vacancy rate, our immediate reaction is to find the cause whether we're competitive with other nurses in the community, whether there is an overall shortage of nurses within the community, whether that shortage is due to some specialty need, or whether it is across the board, what kind of nursing staff it is, LPNs, LVNs, nursing assistants, and then attack that specific issue to assist the medical center. The mechanism for doing that is for the medical center to come in and describe the situation and ask for relief. That relief may be in terms of special pay rates or the relief may be in other terms.

Ms. FERGUSON. In terms of the incentives award, we have authority through Public Law 96-330 to provide the medical center with raises in terms of the issues surrounding scarce-category people. To date, we have had one VA medical center in Madison, for example, ask for this authority as they bring aboard critical-care nurses. For them in this community, this was an issue.

In addition, we have had the authority, and the VA medical center, Washington, D.C. has come forward very recently for premium pay on Saturday for critical-care nurses because of the local impact.

The private sector is taking a hard look at the large incentive bonus pay bill and they are noting, as they did the last time in '77 through '81, that it offers a very short-term relief for the moment. But the long-term relief has not been offered as nurses in the major metropolitan areas tend to see who has what today and move very rapidly to that setting. So the large incentive bonus pay is coming in for a great deal of study.

I would like to add that I will be leaving this evening for England for a very brief board meeting of the Royal College of Nursing. I received a newsletter and the issues that we speak of are universal in the developed world. Their nurses are marching on Parliament with the statement "no future, no nurses". These issues are there.

The University of Pennsylvania is holding a session with Eli Ginsberg at the end of next month, to which I have been invited, to look at this whole critical issue of supply and demand. I noted last evening on PBS that McNeil-Lehrer addressed it. So money is one of the issues we are throwing at it, and we have had a great deal of relief in some major centers with the special salary rate. But we are looking to other remedies that are coming forth from the long-range stategies committee to deal with what this time around is a major crisis for the developed world.

Mr. LINDSEY. Dr. Gronvall has asked me to relate to you that we have initiated approximately 200 special pay rate authorizations for nurses since December of last year.

Dr. ROWLAND of Georgia. I apologize to my colleagues, but I have to pursue this just a little bit further.

Isn't it true that you're under OMB constraints now and that is one of the reasons that we still continue to have this shortage?

Dr. GRONVALL. In regard to special pay, we do not have a constraint from OMB in adopting special pay rates for nurses or some other staff. The action to approve a special pay rate which elevates the pay doesn't produce any more money in our budget, so we have to find the source to fund that internally. But we are not under any OMB or other constraint in making those special pay agreements.

Dr. ROWLAND of Georgia. Then I don't suppose that you would be opposed to us having some legislation that would tie incentive payments to agreements to sign contracts for maybe 2, 3 or 4 years, if we put that in legislation and were able to tie that to certain amounts.

For example, we might say, if you sign a contract for a year, we will give you a bonus of $1,500; if you sign it for 3 years, $2,000; if you sign it for 3 years, $2,500 and so forth. You would not be opposed to legislation that would do that?

Dr. GRONVALL. Similar legislation, of course, is under consideration in the Senate, and we have testimony that has been developed to comment on that. We have some significant problems with regard to some unanswered questions about what the total impact of that legislation would be and some downsides to it. But as a generalization, again, I go back to my original statement, we would want to work with the committee on that or any other such legislation to be sure that we share a sense with the committee that the proposal would produce an improvement. In that context we support actions that we're taking and, if necessary, new legislation to allow us to take additional actions that are targeted toward improving our recruitment and retention.

We would be pleased to work further with you on the specific suggestion you make.

[See p. 157.]

Dr. ROWLAND of Georgia. I have some additional comments but I will yield to my colleague, Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate your kind consideration because I do have this very important Staggers Act hearing to go to.

Dr. Gronvall, I am really trying to understand. I guess, in general, I am supportive of this legislation. But I also want to try to understand it. I want to understand the potential impact that it may have on the VA, and if it has a bad impact on the VA, it would affect veterans. Then I'm concerned about that.

Dr. GRONVALL. Excuse me. Are you talking about the outpatient care?

Mr. BILIRAKIS. I'm still on outpatient care.

Dr. GRONVALL. Thank you. I just wanted to be sure.

Mr. BILIRAKIS. I'm sorry.

On page 2, in the middle of page 2 of your prepared statement, where you talk about "may furnish needed outpatient care", et cetera, and then you go on to say, "Essentially, comprehensive outpatient care may also be furnished to veterans of World War I or earlier wars," et cetera, et cetera. Then you go on and say—and you repeated this a few minutes ago—"Other veterans are eligible for outpatient care only if it is needed—" I emphasize "—only if it is needed to prepare them for hospital care, to obviate the need for hospital care, or if the care is required as a follow up," et cetera.

I guess my question still is, if an outpatient clinic has as its rules and regulations that they would limit the patients that they will see to a service-connected disability or to service-connected veterans rated at least 50 percent disabled for any disability, then that doctor will not have an opportunity to see that patient who doesn't qualify under those guidelines in order to determine whether or not there is a need for hospital care, or to prepare them for hospital care.

Do you see what I'm saying? I'm talking about the real world situation—and I'm not complaining. I am just grateful, on behalf of all the veterans in my area, that we have an outpatient clinic in Pasco County, FL. We are really very grateful, so I'm not complaining. But the real world of that outpatient clinic is, whether it be lack of facilities, lack of size, whatever the case may be, if you come in as a category A but don't have that 50 percent or better disability, they won't see you. And for good reason. They're taxed. Their facilities and their personnel are completely taxed. So that particular individual will not have an opportunity for a medical evaluation to determine whether additional care is needed to obviate the need for hospital care.

I guess what I'm asking is, that statement "only if it is needed", does that apply to all outpatient clinics?

Dr. GRONVALL. It applies to all outpatient care, whether it is given at an outpatient clinic or in a hospital outpatient department in an existing medical center.

Perhaps this comment will be helpful. Our procedure, as it exists now, requires that when a veteran comes seeking care and applies for care, a medical exam and a medical decision must be made in every case as to what kind of care, if any, is needed.

Mr. BILIRAKIS. Required, regardless of qualifications?

Dr. GRONVALL. Yes. The fact that someone is not eligible for care does not mean that that person is turned away without a medical judgment being made as to what kind of care is needed.

I made the comment, for example, that if a medical judgment is made that the person is in need of emergency care, even if the individual is a nonveteran, we would provide the care that is needed on an emergency basis and work out the paperwork later as to how somebody should pay for it or whatever.

Mr. BILIRAKIS. Again, this is not in the form of a complaint. Frankly, they are doing a good job and we're getting good reports, 99.9 percent good reports, so this is not by way of complaint. But that is not taking place in our clinic.

Dr. GRONVALL. I would surely be pleased, perhaps as a follow up, to receive from you the specific instance you talk about. We would review the problem.

Mr. BILIRAKIS. I don't want to turn off those people. The medical doctors are doing a fantastic job.

Okay. I would be glad to share that with you.

Dr. GRONVALL. We would be pleased to follow up.

Mr. BILIRAKIS. I know I had a very lengthy letter the other day, which I plan to share with the chairman of the Committee—and this is not exactly on point. But this individual has a service-connected disability. But for another problem, which was not service-connected, he did not go to the veterans hospital. He went to a private hospital down there in Tampa and before—everything came out in a wash. Before it was determined that he should be transferred to a veterans hospital, he incurred a $25,000 bill. He lost a leg in World War II, as a matter of fact. But he did not go in connection with that. He is the kind of person who wants to pay his bills. He is now, for the first time in his life, pleading for some help, because he knows he would not have had that bill had he gone to the VA hospital. But it wasn't a service-connected disability and he figured he wasn't going to be able to get treated for it. He did not go to this clinic or any other clinic as maybe he should have done. But he if had gone to our clinic, he probably would have been turned away because the problem that he had was not connected to the service-connected disability, which I think he indicated was over 80 percent. I don't know. It was less than 100 percent. I'm not sure how you can lose a leg and have a small amount of disability. He has never even complained about that.

So I guess what I'm saying is that that person would probably have been turned away—again, not to malign our people there because they do a great job—but the facilities would not afford him the opportunity. They would have turned him away and he would have gone to this private hospital and incurred this bill, as he already has. That is why I am so greatly concerned about all of this.

In the interest of time, I guess maybe I won't ask for an answer from you here, but I would sure like to find out more about it and would certainly welcome the opportunity to share with you some of the history as far as our clinic is concerned.

It is in the process of being expanded and possibly the expansion will take care of this problem anyhow. I would certainly hope so.

Dr. GRONVALL. If I may, just a very quick response. I would look forward to receiving the letter so that we could follow up on the

individual case. But again, as a general answer, a service-connected veteran with a disability rating 50 percent or greater who comes to us, whether it's a hospital or outpatient clinic, is categorically eligible for outpatient care for any medical condition, whether or not it is related to the problem that led to the service-connected disability rating in the first place. So that veteran would have been categorically and fully eligible for outpatient care and would have received it.

Mr. BILIRAKIS. I believe this was over 50 percent.

Dr. GRONVALL. Then there would be no question of that.

Mr. BILIRAKIS. He was under the impression, apparently, that he didn't qualify, which is maybe all of our fault in terms of not disseminating the information adequately.

Dr. GRONVALL. We would be glad to look into the individual case.

[See p. 158.]

Mr. BILIRAKIS. Thank you, Dr. Gronvall.

Thank you, Mr. Chairman. I'm sorry I took so long and I appreciate the time.

Dr. ROWLAND of Georgia. Thank you.

Before I recognize Mr. Evans, there is one question regarding personnel that I want to ask Dr. Gronvall.

In your testimony you didn't support the provision in the draft bill which would exempt temporary or part-time research personnel from VA personnel ceilings. What is your view of the problem and what is the administrative solution that was mentioned in your statement?

Dr. GRONVALL. I would be pleased to answer that. Let me very quickly define the problem.

Within the VA we have many highly-qualified research physicians who are successful in competing for funds from outside the VA. Sometimes those are funds from the National Institutes of Health, often they are funds from private sponsors or donations intended to support research work. When we receive those funds, the investigator usually needs to hire additional personnel to work on the research project. Because we operate under an FTEE ceiling that applies to our total set of activities in medical care and research, we unhappily find ourselves in the position where we can't allow the investigator to hire even temporary research personnel for the period that they would be supported out of the research funds. That problem absolutely does need solution.

As we prepared for this hearing and reviewed the draft legislation which would solve that problem, it was suggested to us, just within the past couple of days, that there may be a way administratively, between the Veterans' Administration and the Office of Management and Budget, to renegotiate the ceiling in our medical care support system so that we would not be in the position of impeding research.

I think all of the details of that administrative solution have not been worked out and I will be pursuing that matter and would be pleased to make subsequent comments back to the committee if it appears there continues to exist a problem after we have exhausted the administrative solution that appears now may solve the problem for us.

[Subsequently, the Veterans' Administration furnished the following:]

The Veterans' Administration will notify the committee when the administrative solution has been worked out with the Office of Management and Budget.

Dr. ROWLAND of Georgia. Thank you very much.

Congressman Tim Johnson, a member of the full committee, as well as the Blinded Veterans Association and AMVETS, have requested they be allowed to submit testimony for inclusion in the hearing record. And there are also questions that other members might want to submit. Without objection, it is so ordered.

[The statements appear at pp. 161, 162 and 164.]

Dr. ROWLAND of Georgia. Mr. Evans.

Mr. EVANS. Thank you, Mr. Chairman. I will try to wrap up in a few minutes. I do have some questions that I will submit for the record as well. I appreciate you're giving me another bite on the apple, but I did want to yield to the doctor for his explanation in regard to the meeting on the budget issues.

Dr. GRONVALL. Yes. I believe the meeting that was referred to, because I was there, was one of the routine, internal preparation sessions that we have as we prepare for congressional hearings, in this case on the 1988 budget.

When we have one of those sessions, we within the VA try to put before ourselves every question that we think may be asked as we get into congressional reviews. So while the purpose of the meeting was to prepare for a budget hearing, all manner of things get discussed and commented on.

The fact that the conversation between the Administrator and the General Counsel occurred in a budget preparation session does not in any way mean that the question was motivated by budget stringency or had any direct relation to the budget. As I say, all kinds of discussions go on in those preparation sessions.

Mr. EVANS. Going back to that meeting, I heard Mr. Ivers talk about what he said. Did the Administrator at any point interrupt the briefing on the veterans outreach center program and say something to the effect that these centers needed to be totally integrated into the hospitals? Do you recall that?

Dr. GRONVALL. I surely don't have that recollection and I don't remember anything that was either dramatic or a policy statement that we were going to integrate the vet center program into the medical centers. The matter being discussed had to do with whether or not we could make the nine vet center relocations. The question was asked whether the VA had the authority to go ahead with that, even though we weren't yet into the legislatively-mandated transition period. Mr. Ivers responded, as he did here, and the meeting moved on. I don't remember it as a dramatic event.

Mr. EVANS. The law requires the VA to supply Congress with an annual report of the Chief Medical Director's Special Committee on PTSD by March 1 of each year. I understand that these annual reports have been submitted on time, as required, by January 1, but that the VA has delayed forwarding the reports to Congress for as much as a year. Is that true?

Dr. GRONVALL. I don't, to my own knowledge as I sit here, know the exact timetable. I know that the reports have not been submitted on time.

[See p. 159.]

Mr. EVANS. Does this indicate a willingness or an intention on the part of the VA to prevent Congress from having access to this information because the committee supports the outreach program so strongly?

Dr. GRONVALL. You're asking me, of course, to comment on other people's intent, so I really can't comment on that because I can only judge by actions that I see as people deliberate on matters. So I don't really know how to answer the question.

Mr. EVANS. I guess intent, whether it is congressional or VA intent, is always hard to discern, admittedly. But I guess if we have to base our judgments on those same kinds of actions, it is very disturbing to us that we don't get the reports.

Now, these reports in the past, the first and second annual reports, have basically said that PTSD can be a devastating problem. To quote from the second report, "If untreated, it often gets worse with time. If there really is a national commitment to provide treatment for combat veterans with PTSD, then there must be a national willingness to provide that treatment." In addition, the special committee has indicated that the outreach centers are an extremely valuable part of the matrix of services that need to be offered to provide treatment for PTSD. So I guess I would ask your personal opinion, going back to the question that I had asked earlier.

Given the fact that you have so much strong support for these outreach centers from your own Special Committee on PTSD, most of whom are medical practitioners—and I noticed in a letter to Chairman Montgomery, where you're basically responding to his letters about this whole issue, saying you need to go ahead because of the statutory requirement for more extensive relocations—really, don't you think, personally, that maybe it might be better if we looked at the transition period from the law?

Dr. GRONVALL. Let me say that the quote you read is one which I totally agree with, professionally and personally, and support. It is my personal judgment, as an individual and as a physician, that there is a problem with PTSD and that the vet center program has made a major contribution to ameliorating that problem in this country.

In my view, however, the issue of whether the vet center mission is carried out in a physical location that is separate from a medical center, or close to or integrated into a medical center, is a very different question. In my view, it is responsible to relocate some, many, or a majority of the vet centers to medical center grounds and assess the impact that that has on the vet center mission, both pro and con.

As I think I commented earlier, there are some ways in which the other medical staff could assist in expanding the support available to Vietnam veterans in that setting. There are some concerns obviously, about whether Vietnam veterans will, in the same number, utilize those services in that geographic location. It is because of those uncertainties that we felt taking this initial step to

gain some experience in a limited way on that issue was a valuable and appropriate step to take.

Mr. EVANS. Can you tell us a little bit about the chronology involved? I understand that you basically approved the criteria for selecting the nine sites on January 20, 1987, and that the list was then finalized by January 23, 1987. Is that correct?

Dr. GRONVALL. I would have to consult records to speak to exact dates, but I believe those are accurate dates at which my formal approval on the set of criteria was given and my approval of the recommendation of the specific sites.

The criteria had been presented to our so-called policy advisory board and deliberated there. Right after that meeting, I was briefed on the criteria that had been presented and the way in which they were going to then come to me for final approval. The criteria had been basically developed by our readjustment counseling staff and deliberated on. When I was briefed, at the time of that meeting I said that those appeared to me to be reasonable criteria.

We were proceeding at the same time with consideration of specific sites that might meet those criteria. I believe that the time between my formal approval, when the paperwork finally came to me to approve the criteria, and the transmission of a memo recommending the nine specific sites, in fact, is not an accurate reflection of the progress of the deliberation as it proceeded.

All of this is a matter of record which can be easily produced, of course.

Mr. EVANS. I guess I would like to have that, if you could clarify by written response on what that time period is.

[The requested information appears on p. 160.]

Dr. GRONVALL. I would be pleased to.

Mr. EVANS. But was this Special Committee on PTSD ever advised of this? I guess you have told me in your first letter that the advisory committee was not advised as to these relocations; is that correct?

Dr. GRONVALL. I believe that's correct. And as far as the Special Committee is concerned, I do not know whether they were aware of it. To my knowledge, we did not consult with them, but I would again have to ask that question and consult the records.

Mr. EVANS. I wish you would do that, because it is important to us. I know these committees are advisory, but if we are going to have advisory committees, it would be good to give them the benefit of being able to advise. I don't know exactly what role the special committees have. I know they prepare these reports that we request and so forth.

I guess, in determining which sites should be relocated under your reading of congressional intent, that we should be trying to involve as many people in this process as possible. That's my only comment, I guess. Do you have a follow up?

Dr. GRONVALL. I would be pleased to respond to you as to the process that was followed and what was and was not done.

[Subsequently, the VA submitted the following information:]

As indicated above, the nine vet centers submitted for relocation to VA medical centers were evaluated by RCS and medical region officials to include relevant field level staff. Official notification of the Agency's plan to move these nine vet centers to VA medical centers was given to the veteran service organization leadership and

to the relevant congressional leadership (regional and committee) in correspondence of February 1987, signed by the Administrator. I regret that neither the Agency Advisory Committee on the Readjustment of Vietnam Veterans nor the CMD's Special Committee on PTSD were advised in advance of this project. All committee membership has subsequently been informed.

Mr. EVANS. Thank you for your time.

Mr. Chairman, I thank you for your indulgence.

Dr. ROWLAND of Georgia. Thank you, Mr. Evans.

We have been here a long time, but there is one question I wanted to ask Miss Ferguson. If you could condense your answer, I would appreciate it.

I would like to know, in your personal opinion, what are the three most serious needs requirements to alleviate the nurse recruiting and retention problems that we're having?

Ms. FERGUSON. One would be more personnel to reduce the workload. One other would be the extension of computerization to assist nurses on units to get doctors' orders and get things moving, rather than in a hand mode as is present in many settings. Another would be to evaluate the large range of financial remedies and sort them out as to which one would be of most benefit within the available resources. We have been putting the third one into discussion in the long-range strategy committee, arguing the pros and cons of each position. So I would put those three things forth.

When I speak of computerization, I would slash that with support services, to assist a nurse to give direct patient care, rather than the large number of other things. In today's world, with many other people in support services also requiring large salaries, responding with computerized systems might help bridge that gap.

Dr. ROWLAND of Georgia. I guess we could get off on the decentralized hospital programs here but we don't have time for that.

Dr. GRONVALL. We would be pleased to make comments on that, if you wish.

[Laughter.]

Dr. ROWLAND of Georgia. I am sure you would. We're all on the same side there.

Let me thank all of you very much for being here. It has been a rather long hearing.

Dr. Gronvall, did you have a comment?

Dr. GRONVALL. Mr. Chairman, at the beginning of the hearing this morning, Mr. Montgomery referred to a General Accounting Office report that has been released.

Dr. ROWLAND of Georgia. Yes, and I would ask you to comment on it.

Dr. GRONVALL. I am prepared to comment on it, if you want me to.

Dr. ROWLAND of Georgia. Proceed.

Dr. GRONVALL. I think I can do it in 2 or 3 minutes, 5 minutes at the most.

Dr. ROWLAND of Georgia. Yes. Would you do that.

Dr. GRONVALL. I am pleased to do so.

The General Accounting Office issued a report focused on the so-called patient injury control program of the VA. That is one part of the total quality assurance effort and is an important part that falls within the responsibility of our medical inspector.

We commented on the GAO report, of course, when it was in draft phase and agreed with the substance of their recommendations, namely, that we needed to take some very specific steps to improve the reporting of accidents and injuries to our patients. We disagreed with the title that the General Accounting Office was putting on the report. They used a title saying that our reporting system was ineffective. In our view, it has serious problems which need to be fixed, so we wanted a different title. But they did not accept that suggestion.

In the body of the report itself, in fact, in the summary of the conclusions, the General Accounting Office makes the following statement: "The actions being taken or planned by the VA should make the program more effective." So there is recognition in the body of the report, if one examines it, that in fact we are taking steps to make this an effective program.

I am not saying that the program does not have significant shortcomings. Those are documented and we agreed. The matter at issue is basically a reporting system for untoward incidents and accidents and the problem is significant under-reporting. The data they reviewed came from the 1984-85 year, during which year some 85,000 or 86,000 such incidents were, in fact, reported through that system. But in an audit in some individual medical centers, the GAO auditors found that many other incidents occurred which, for various reasons documented in the report, did not get reported.

The GAO report does not make the assertion that quality of care in the VA is substandard, deficient, or that veterans are at risk or that there is jeopardy to individual veterans who are being cared for. In fact, I believe that we have now a very significant and dramatic record of action when there is evidence that quality of care concerns exist. Our recent extensive review of our open heart surgery program is the best case in point, where we did have evidence to raise concern directly about quality of care. We stepped in, reviewed all of our programs, and as you know, took the step of actually closing cardiac surgery at four of our medical centers in order to ensure that quality of open heart surgery would be enhanced.

I have said widely that my goal as Chief Medical Director is to ensure that quality of care for veterans is second to none, that accepts the best quality care available in university hospitals and in community hospitals as the goal and marker and objective of the VA. If I am aware of areas where we are falling short, it is my intent to take action, dramatic, if necessary, as we did with cardiac surgery, to ensure that care of a questionable quality is not being given in the VA medical centers.

I would just close by saying that we have appreciated very much the leadership of this committee, the chairman and members of this committee, in working with us, to help us. As in recent years, we have expanded and built a quality assurance mechanism that, to my personal knowledge, is more extensive than exists in any private sector chain of hospitals. I think you're quite right in the comments that were made earlier, that the fact that we are a Federal hospital system means we operate in a fishbowl. I am not dismayed or disturbed by that. That is only appropriate and we should operate fully in the public eye.

I think, again, based on my own private knowledge of having worked in hospitals outside the VA, and from my recent experiences in discussing this whole matter with colleagues outside the VA, that we are well ahead of the private sector on these reporting and review requirements. They make a contribution to care, but I would just close by saying that reporting or, in this case, lack of reporting, should not be translated directly by anyone to a direct concern about the quality of anything that happened to any veteran that was in one of our hospitals.

We will be working on the additional steps to improve not only our patient injury control system but the other parts of our quality assurance program, and we look forward very much to presenting those to the committee and working with the support of this committee as we take these additional steps.

Dr. ROWLAND of Georgia. I quite agree with you on the quality of care in the VA. I am very pleased with the quality of care. We do operate in a fishbowl in the VA and public attention is focused on it. The least little misstep certainly is cause for immediate attention. We realize, as in the VA, that, as politicians, that that's the way it is.

Dr. GRONVALL. We accept that.

Dr. ROWLAND of Georgia. So we operate in that manner.

I thank all of you again very much for being here.

Dr. GRONVALL. Thank you very much, Mr. Chairman.

[Whereupon, at 12:30 p.m., the subcommittee was adjourned.]

APPENDIX

I

100TH CONGRESS
1ST SESSION

H. R. 2001

To amend title 38, United States Code, to extend the adult day health care program and authorize contract halfway house care for veterans with chronic psychiatric disabilities.

IN THE HOUSE OF REPRESENTATIVES

APRIL 8, 1987

Mr. MONTGOMERY (for himself and Mr. SOLOMON) (both by request) introduced the following bill; which was referred to the Committee on Veterans' Affairs

A BILL

To amend title 38, United States Code, to extend the adult day health care program and authorize contract halfway house care for veterans with chronic psychiatric disabilities.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) this Act may be cited as the "Alternative Care Amendments Act of 1987".

(b) Except as otherwise expressly provided, whenever in this Act an amendment is expressed in terms of an amendment to a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

SEC. 2. (a) Paragraph (3) of subsection (f) of section 620 is amended by striking "1988" and inserting in lieu thereof "1991".

(b) The Veterans' Health Care Amendments of 1983 (Public Law 98–160, 97 Stat. 993) is amended in section 103(c) by striking "1988" and inserting in lieu thereof "1991".

SEC. 3. (a) Subchapter II of chapter 17 is amended by adding at the end the following new section:

"§ 620B. Contract treatment for veterans with chronic psychiatric disabilities

"(a)(1) The Administrator may contract for care, treatment, and rehabilitative services in halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities for any veteran described in section 612(a)(1)(B) or section 612(f)(1)(A)(ii) who is suffering from a chronic psychiatric disability.

"(2) Before furnishing such care and services to any veteran through a contract facility, the Administrator shall approve (in accordance with such criteria as the Administrator may prescribe) the quality and effectiveness of the program operated by such facility for the purpose for which such veteran is to be furnished such care and services.

"(b) The Administrator may not contract for care, treatment, and rehabilitative services under subsection (a) of this section after September 30, 1991.".

(b) Not later than March 31, 1991, the Administrator shall report to the Committees on Veterans' Affairs of the Senate and House of Representatives on the findings and recommendations of the Administrator pertaining to the operation of the program authorized by this section.

(c) The table of sections at the beginning of chapter 17 is amended by inserting after the item relating to section 620A the following new item:

"620B. Contract treatment for veterans with chronic psychiatric disabilities.".

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100TH CONGRESS
1ST SESSION

H. R. 2002

To amend title 38, United States Code, to authorize the Administrator of Veterans' Affairs to provide on call pay to certain civil service health-care personnel.

IN THE HOUSE OF REPRESENTATIVES

APRIL 8, 1987

Mr. MONTGOMERY (for himself and Mr. SOLOMON) (both by request) introduced the following bill; which was referred to the Committee on Veterans' Affairs

---

A BILL

To amend title 38, United States Code, to authorize the Administrator of Veterans' Affairs to provide on call pay to certain civil service health-care personnel.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 4107 of title 38, United States Code, is amended by deleting the period at the end of subsection (i), inserting a semicolon in lieu thereof, and adding the following:

"(j) Notwithstanding any other provision of law, a health care employee, or employee providing services incident to health care, employed pursuant to title 5 or section 4104(3) of this title, who is officially scheduled to be on call

outside his or her regular hours or on a holiday designated by Federal statute or Executive order shall be paid at a rate equal to 10 per centum of the hourly overtime rate for services in excess of his or her regularly scheduled duty for each hour of such on call duty, except for such time as he or she may be called back to work.".

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100TH CONGRESS
1ST SESSION

H. R. 2003

To amend title 38, United States Code, to authorize the Chief Medical Director to waive State licensure requirements for registered, practical or vocational nurses and physical therapists not to be employed in patient care, and for licensed or vocational nurses and physical therapists to be employed in a foreign country.

IN THE HOUSE OF REPRESENTATIVES

APRIL 8, 1987

Mr. MONTGOMERY (for himself and Mr. SOLOMON) (both by request) introduced the following bill; which was referred to the Committee on Veterans' Affairs

---

A BILL

To amend title 38, United States Code, to authorize the Chief Medical Director to waive State licensure requirements for registered, practical or vocational nurses and physical therapists not to be employed in patient care, and for licensed or vocational nurses and physical therapists to be employed in a foreign country.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That subsection (d) of section 4114 of title 38 is amended to read:

"The Chief Medical Director may waive for the purpose of appointments under this section the requirements of sec-

tion 4105(a) of this title that the licensure or registration, as appropriate, of a physician, dentist, podiatrist, psychologist, optometrist, registered nurse, practical or vocational nurse, or physical therapist must be in a 'State', if the person is to—

"(1) be used in a research or an academic post or where there is no direct responsibility for the care of patients; or

"(2) serve in a country other than the United States and such person's licensure or registration is in the country in which the person is to serve.".

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100TH CONGRESS
1ST SESSION

H. R. 2004

To amend title 38, United States Code, to clarify the authority of the Chief Medical Director or designee regarding disciplinary actions on certain probationary title 38 health care employees.

IN THE HOUSE OF REPRESENTATIVES

APRIL 8, 1987

Mr. MONTGOMERY (for himself and Mr. SOLOMON) (both by request) introduced the following bill; which was referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to clarify the authority of the Chief Medical Director or designee regarding disciplinary actions on certain probationary title 38 health care employees.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 4106(b) of title 38, United States Code, is amended to read as follows:

"(b) Appointments under section 4104(1) of this title shall be subject to a probationary period of two years. The record of performance of each person serving under such appointment may be reviewed at any time during that period by

a board or boards appointed in accordance with regulations issued by the Administrator. Procedures governing the review of employee performance during the probationary period shall be established in regulations issued by the Administrator. The board(s) shall recommend to the Chief Medical Director, or designee, action consistent with the ability of the employee, as determined by the board(s), to perform efficiently. The Chief Medical Director, or designee, may accept, reject, or modify the recommendation of the board(s). If the Chief Medical Director, or designee, takes action not recommended by the board(s), a statement of the reasons therefor shall be prepared and made part of the record.".

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100TH CONGRESS
1ST SESSION

H. R. 2006

To amend title 38, United States Code, to improve the administration of veterans' health-care benefits, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

APRIL 8, 1987

Mr. MONTGOMERY (for himself and Mr. SOLOMON) (both by request) introduced the following bill; which was referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to improve the administration of veterans' health-care benefits, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) this Act may be cited as the "Veterans' Health Care Benefits Administration Act of 1987".

(b) Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

(c) Section 603(a) is amended—

(1) by inserting the words "receiving nursing home care in a public or private nursing home in the community under section 620 of this title or" after the word "veteran" the first time it appears in paragraph (3);

(2) by striking the word "or" at the end of paragraph (6);

(3) by inserting "; or" in lieu of the period at the end of paragraph (7); and

(4) by adding at the end a new paragraph as follows:

"(8) hospitalization of a person for observation and examination to determine eligibility for a benefit under a program administered by the Veterans' Administration.".

(d) Section 620(a)(2) is amended—

(1) by inserting the words "in the State in which such institution is located" after the word "Administrator" the first time it appears in clause (A);

(2) by striking the period at the end of clause (B) and inserting "; or" in its place; and

(3) by inserting a new clause (C) as follows—

"(C) the amount equal to 50 percent of the cost of care furnished by a community general hospital under contract with the Veterans' Admin-

istration (as such cost may be determined annually by the Administrator) in Alaska or Hawaii.".

(e) Section 624(b) is amended to read as follows:

"(b) The Administrator may furnish necessary hospital care and medical services to any otherwise eligible veteran who is sojourning or residing abroad (A) for a service-connected disability, or (B) when care or services are needed to enable continued participation in a rehabilitation program under chapter 31 of this title.".

(f) Section 201 of the Veterans' Health Care Amendments of 1979 (Public Law 96-22, 93 Stat. 54; 38 U.S.C. 601, note 1) is amended by striking subsection (b).

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100TH CONGRESS
1ST SESSION

H. R. 2007

To amend title 38, United States Code, to revise and clarify VA authority to furnish certain health care benefits, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

APRIL 8, 1987

Mr. MONTGOMERY (for himself and Mr. SOLOMON) (both by request) introduced the following bill; which was referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to revise and clarify VA authority to furnish certain health care benefits, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) this Act may be cited as the "VA Health Care Amendments Act of 1987".

(b) Section 101(28) of title 38, United States Code, is amended to read as follows:

"(28) The term 'nursing home care' means the accomodation of convalescents or other persons who are not acutely ill and not in need of hospital care, but who require nursing and health related services, if such nursing care and health

related services are prescribed by, or are performed under the general direction of, persons duly licensed to provide such services. The term includes services delivered in skilled, intermediate care, and combined facilities. It does not include domiciliary or residential care.".

(c) Section 601(4) of such title is amended by deleting the word "and" in paragraph (A), inserting "; and" in place of the period in paragraph (B), and adding the following new paragraph at the end:

"(C) public or private facilities at which the Administrator provides recreational activities for patients who are receiving care under section 610 of this title."

(d) Section 610(b) of such title is amended to read as follows:

"The Administrator, within the limits of Veterans' Administration facilities, may furnish domiciliary care to a veteran who is in need of domiciliary care if such veteran is unable to defray the expenses of necessary care.".

(e) Section 612(a)(1) of such title is amended:

(1) by deleting the word "and" and the end of clause (A);

(2) by deleting the period at the end of clause (B) and inserting "; and" in its place; and

(3) by inserting a new clause (C) as follows:

"(C) to any person (i) for a disability for which the person is in receipt of compensation under section 351 of this title or, (ii) for a disability for which the person would be entitled to compensation under section 351 of this title, but for a suspension pursuant to that section, but only to the extent that such person's continuing eligibility for medical services is provided for in the judgment or settlement described in such section."

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100TH CONGRESS
1ST SESSION

H. R. 2010

To amend title 38, United States Code, to authorize modification of the structure of the Office of the Chief Medical Director, to clarify procedures for removal for cause of certain employees, to authorize the use of the Director Pay Grade within Veterans' Administration Central Office and for related purposes.

IN THE HOUSE OF REPRESENTATIVES

APRIL 8, 1987

Mr. MONTGOMERY (for himself and Mr. SOLOMON) (both by request) introduced the following bill; which was referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to authorize modification of the structure of the Office of the Chief Medical Director, to clarify procedures for removal for cause of certain employees, to authorize the use of the Director Pay Grade within Veterans' Administration Central Office and for related purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 4103 of title 38, United States Code, is amended as follows:

(a) paragraph (3) of subsection (a) is amended to read as follows:

"(3) Not to exceed two Associate Deputy Chief Medical Directors, who shall be assistants to the Chief Medical Director and the Deputy Chief Medical Director, appointed by the Administrator upon the recommendation of the Chief Medical Director.".

(b) by striking out paragraphs (4) through (9) of subsection (a).

(c) Subsection (b) is amended to read as follows:

"(b) In addition, the Office of the Chief Medical Director may consist of the following:

"(1) Not to exceed seven Assistant Chief Medical Directors, who shall be appointed by the Administrator upon the recommendation of the Chief Medical Director and who shall be qualified doctors of medicine, dental surgery or dental medicine, except that not more than two Assistant Chief Medical Directors may be persons qualified in the administration of health services who are not doctors of medicine, dental surgery or dental medicine.

"(2) Such Medical Directors as may be appointed by the Administrator, upon the recommendation of the Chief Medical Director, to suit the needs of the Department. A Medical Director may be a qualified doctor of medicine, dental surgery or dental medicine

or a registered nurse qualified in nursing administration.

"(3) Such Directors as may be appointed by the Administrator, upon recommendation of the Chief Medical Director, to suit the needs of the Department.

"(4) Such directors of hospitals, domiciliary facilities, medical centers, and outpatient facilities as may be appointed by the Administrator upon the recommendation of the Chief Medical Director.

"(5) Such other persons as may be appointed by the Chief Medical Director with the approval of the Administrator to fill positions deemed necessary to accomplish the mission of the Department.".

(d) Subsection (c) is redesignated as subsection (f).

(e) By inserting the following new subsections:

"(c) The Chief Medical Director, with the approval of the Administrator, may establish, consolidate, eliminate, abolish, redistribute, or modify such positions and offices as he deems needed for the Department of Medicine and Surgery to carry out its mission.

"(d) Any appointment under section 4103(a) and (b) shall be for a period of four years, with reappointment permissible for successive like periods. Any such appointment or reappointment may be extended by the Administrator for a period not in excess of three years. Any person appointed or

reappointed, designated or redesignated pursuant to this section, including subsection (f), or whose appointment or reappointment, designation or redesignation is extended shall be subject to removal for cause in the same manner and under procedures similar to those set forth in section 4110 of this title. The members of the Disciplinary Boards in such cases may be any persons appointed pursuant to this subsection.

"(e) The appointment, reappointment, or extension of appointment or reappointment of any person pursuant to subsections (a) and (b), whose position is abolished in accordance with subsection (c), shall terminate. Any person who relinquished an appointment made pursuant to section 4104(1) in order to accept an appointment under this section and whose appointment, reappointment, or extension of appointment or reappointment under this section is terminated by reason of abolishment of position, shall be entitled, upon such termination, to reemployment under section 4104(1). Any person who relinquished an appointment in the Federal civil service in order to accept an appointment under this section who at the time of such appointment shall have had a civil service status, and whose appointment, reappointment, or extension of appointment or reappointment under this section is terminated by reason of abolishment of position, shall be entitled to reappointment in the Federal civil service in accordance with

his or her reinstatement eligibility by virtue of previous civil service appointment and status.".

Sec. 2. That section 4107 of title 38, United States Code, is amended as follows:

(a) By striking out in subsection (a) all after "Medical Director, $73,958 minimum to $83,818 maximum." and inserting in lieu thereof "Director, $63,135 minimum to $79,975 maximum.".

(b) By inserting in paragraph 3 of subsection (c) "or any person appointed under section 4103 of this chapter, who is not eligible for special pay under section 4118 of this chapter" after "applies.".

(c) Paragraph 2 of subsection (d) is amended to read as follows: "(2) Level IV for the Deputy Chief Medical Director and the Associate Deputy Chief Medical Directors; and".

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100TH CONGRESS
1ST SESSION

H. R. 2327

To amend title 38, United States Code, to ensure eligibility of certain individuals for beneficiary travel benefits when traveling to Veterans' Administration medical facilities.

IN THE HOUSE OF REPRESENTATIVES

MAY 7, 1987

Mr. SOLOMON (for himself, Mr. MONTGOMERY, Mr. HAMMERSCHMIDT, Mr. EDWARDS of California, Mr. WYLIE, Mr. APPLEGATE, Mr. STUMP, Mr. MICA, Mr. MCEWEN, Mr. DOWDY of Mississippi, Mr. SMITH of New Jersey, Mr. EVANS, Mr. BURTON of Indiana, Ms. KAPTUR, Mr. BILIRAKIS, Mr. PENNY, Mr. RIDGE, Mr. STAGGERS, Mr. ROWLAND of Connecticut, Mr. ROWLAND of Georgia, Mr. DORNAN of California, Mr. BRYANT, Mr. SMITH of New Hampshire, Mr. GRAY of Illinois, Mr. DAVIS of Illinois, Mr. KANJORSKI, Mr. STENHOLM, Mr. HARRIS, Mr. KENNEDY, Mrs. PATTERSON, Mr. JOHNSON of South Dakota, Mr. JONTZ, Mr. LEWIS of Florida, Mr. MCCURDY, Mr. ANNUNZIO, Mr. HORTON, Mr. CHAPPELL, Mr. MCDADE, Mr. MARTIN of New York, Mr. FAUNTROY, Mr. DANIEL, Mr. YATRON, Mr. HEFNER, Mr. OBEY, Mr. SISISKY, Mr. LEATH of Texas, Mr. PERKINS, Mr. THOMAS of Georgia, Mr. HOWARD, Mr. RICHARDSON, Mr. COLEMAN of Texas, Mrs. LLOYD, Miss SCHNEIDER, Mr. NICHOLS, Mr. DEFAZIO, Mr. CLARKE, Mr. DERRICK, Mr. SMITH of Florida, Mr. STANGELAND, Mr. ST GERMAIN, Mr. PARRIS, Mr. MCCOLLUM, Mr. ENGLISH, Mr. FLIPPO, Mr. JONES of North Carolina, Mrs. SMITH of Nebraska, Mr. MILLER of Ohio, Mr. KOLTER, Mr. RAHALL, Mr. KLECZKA, Mr. DURBIN, Mrs. MORELLA, Mr. MANTON, Mr. OBERSTAR, Mr. LAGOMARSINO, Mr. TORRES, Mrs. SAIKI, Mr. BOEHLERT, Ms. SLAUGHTER of New York, Mr. MCCLOSKEY, Mr. MARLENEE, Mr. LANCASTER, Mr. ORTIZ, Mr. PORTER, Mr. SIKORSKI, Mr. SWEENEY, Mr. HOCHBRUECKNER, Mr. HOLLOWAY, Mr. DE LA GARZA, Mr. PETRI, Mr. TRAFICANT, Mr. DORGAN of North Dakota, Mr. WOLPE, Mr. WOLF, Mr. SWINDALL, Mr. WILSON, Mr. FUSTER, Mr. LENT, Mr. OXLEY, Mr. ROGERS, Mrs. BOXER, Mrs. BENTLEY, Mr. ACKERMAN, Mr. WILLIAMS, Mr. MOLINARI, Mr. MCGRATH, Mr. MCHUGH, Ms. SNOWE, Mr. SABO, Mr. WHITTAKER, Mr. LATTA, Mr. REGULA, Mr. SUNDQUIST, Mr. MARTINEZ, Mr. HUGHES, Mr. TOWNS, Mr. EMERSON, Mr. SLATTERY, Mr. GALLEGLY, Mr. HUTTO, Mr. STRATTON, Mr. PEPPER, Mr. FISH, Mr. TORRICELLI, and

Mr. GALLO) introduced the following bill; which was referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to ensure eligibility of certain individuals for beneficiary travel benefits when traveling to Veterans' Administration medical facilities.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. VETERANS' ADMINISTRATION BENEFICIARY TRAVEL PROGRAM.

(a) ENTITLEMENT.—Subsection (a) of section 111 of title 38, United States Code, is amended—

(1) by striking out "may" both places it appears and inserting in lieu thereof "shall"; and

(2) by striking out "person" and inserting in lieu thereof "eligible claimant or beneficiary".

(b) BENEFICIARIES.—Such section is further amended—

(1) by redesignating subsections (b), (c), (d), and (e) as subsections (c), (d), (e), and (f); and

(2) by inserting after subsection (a) the following new subsection (b)(1):

"(b)(1) The following persons are entitled to payment under this section:

"(A) A veteran traveling in connection with treatment of a service-connected disability.

"(B) A veteran with a service-connected disability rated at 50 percent or more for any disability.

"(C) A veteran receiving or eligible to receive pension under section 521 of this title for any disability.

"(D) A veteran whose annual income (determined in accordance with section 503 of this title) does not exceed the maximum annual rate of pension which would be payable to such veteran if such veteran were eligible for pension under section 521 of this title for any disability.

"(E) A veteran for whom ambulance transportation, wheelchair van transportation, or other special mode of transportation is medically indicated and an administrative determination is made that the veteran is unable to bear the cost of such transportation for any disability.

"(F) A veteran who is determined (under regulations prescribed by the Administrator) to be unable to defray the expenses of the travel for which payment under this section is claimed for any disability.

"(G) Such other persons as the Administrator determines by regulation.

"(2) The purposes for which payments for travel shall be made under this section are those specified in regulations of the Veterans' Administration in effect on July 1, 1986 (38 CFR 17.100, 17.102).

"(3) Payment may not be provided to a person under this section—

"(A) to reimburse for the cost of travel by privately owned vehicle in any amount in excess of the cost of such travel by public transportation unless public transportation is not reasonably accessible or would be medically inadvisable; or

"(B) in excess of the actual expense incurred by such person (as certified in writing by such person).".

(c) CONFORMING AMENDMENTS.—Subsection (f) of such section (as redesignated by subsection (b)) is amended—

(1) by striking out "paragraph (3)(C) of this subsection, and, in any event, immediately following the enactment of this subsection and not less often than annually thereafter, and" in the second sentence of paragraph (1) and inserting in lieu thereof "paragraph (2)(C) of this subsection and, in any event, not less often than annually and,";

(2) by striking out paragraph (2);

(3) by redesignating paragraph (3) as paragraph (2); and

(4) by redesignating paragraph (4) as paragraph (3) and striking out "paragraph (3)(C)" in that paragraph and inserting in lieu thereof "paragraph (2)(C)".

(d) CLERICAL AMENDMENTS.—Subsection (c) of such section (as redesignated by subsection (b)) is amended—

(1) in paragraph (1)—

(A) by striking out "the" and inserting in lieu thereof "The"; and

(B) by striking out "subsection (a) hereof;" and inserting in lieu thereof "subsection (a) of this section";

(2) in paragraph (2)—

(A) by striking out "actual" and inserting in lieu thereof "Actual"; and

(B) by striking out the semicolon at the end and inserting in lieu thereof a period; and

(3) in paragraph (3), by striking out "the expense" and inserting in lieu thereof "The expense".

(e) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to travel expenses incurred after the date of the enactment of this Act.

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100TH CONGRESS
1ST SESSION

H. R. 2146

To amend title 38, United States Code, to extend the transition period for the Veterans' Administration readjustment counseling centers program, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

APRIL 23, 1987

Mr. EVANS (for himself, Mr. STAGGERS, Mr. BRYANT, Mr. FLORIO, Mr. GRAY of Illinois, Mr. JOHNSON of South Dakota, Mr. KENNEDY, Mr. SMITH of New Jersey, and Mr. RIDGE) introduced the following bill; which was referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to extend the transition period for the Veterans' Administration readjustment counseling centers program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. EXTENSION OF INDEPENDENT STATUS OF READJUSTMENT COUNSELING CENTERS.

(a) AMENDMENTS TO SECTION 612A.—Section 612A(g) of title 38, United States Code, is amended as follows:

(1) Paragraph (1) is amended—

(A) in the matter preceding subparagraph (A), by striking out "During" and all that follows through "the Administrator" and inserting in lieu thereof "The Administrator"; and

(B) in subparagraph (A)—

(i) by striking out "October 1, 1989" and inserting in lieu thereof "October 1, 1990"; and

(ii) by striking out "centers located" and all that follows through "such health-care facilities" and inserting in lieu thereof "readjustment counseling centers (as defined in paragraph (6) of this subsection) to a program providing such services primarily through Veterans' Administration general health-care facilities".

(2) Paragraph (2)(A) is amended—

(A) by striking out "April 1, 1987" and inserting in lieu thereof "April 1, 1988"; and

(B) by striking out "(Public Law" and all that follows through "available)".

(3) Paragraph (3) is amended—

(A) by striking out "July 1, 1987" and inserting in lieu thereof "July 1, 1988"; and

(B) by striking out "(or" and all that follows through "available)".

(4) Paragraph (4) is amended—

(A) by striking out "February 1, 1989" and inserting in lieu thereof "February 1, 1990"; and

(B) by striking out "a report on the experience" and all that follows and inserting in lieu thereof "a report on—

"(A) the Administrator's evaluation of the experience under as much of the transition as was carried out pursuant to paragraph (1) of this subsection before September 30, 1989; and

"(B) based on that evaluation, the results of the study required by section 102 of the Veterans' Health Care Amendments of 1983 (Public Law 98–160), and other pertinent information regarding the readjustment counseling program, the Administrator's opinion as to the extent to which the provision of readjustment counseling services under this section through readjustment counseling centers (as defined in paragraph (6) of this subsection) is needed to meet the readjustment needs of veterans who served on active duty during the Vietnam era.".

(5) Such section is further amended by adding at the end the following new paragraphs:

"(5) The Administrator shall maintain in operation until October 1, 1988, the same number of readjustment counseling centers as were in operation on April 1, 1987.

"(6) For the purposes of this subsection:

"(A) The term 'readjustment counseling centers' means facilities which are operated by the Veterans' Administration for the provision of services under this section and which are situated apart from Veterans' Administration general health-care facilities.

"(B) The term 'Veterans' Administration general health-care facilities' means health-care facilities operated by the Veterans' Administration for the furnishing of health-care services under this chapter, not limited to services provided through the programs established under this section.".

(b) REPORT DEADLINE.—Section 102(b) of the Veterans' Health Care Amendments of 1983 (Public Law 98–160; 97 Stat. 994) is amended by striking out "October 1, 1986" and inserting in lieu thereof "October 1, 1987".

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STATEMENT
OF
REPRESENTATIVE SHERWOOD BOEHLERT (R-25-NY)
BEFORE THE
SUBCOMMITTEE ON COMPENSATION, PENSION, AND INSURANCE
COMMITTEE ON VETERAN AFFAIRS
MAY 20, 1987

Once again, veterans in my Congressional District are in shock due to new VA regulations. The Syracuse VA Medical Hospital sent notification that veterans can no longer expect transportation benefits. Unless they meet the amended criteria of new VA regulations, they will not be able to defray transportation expenses to and from scheduled appointments at the Medical Center.

These new regulations, which severely restrict eligibility for veterans, only authorizes travel reimbursement for:

*Travel payments to eligible veterans who use specialized modes of transportation, such as ambulance/wheelchair van.
*Travel in conjunction with compensation and pension examination;
*Travel over a 100-mile radius from the nearest medical facility;
*Transport costs, when required, to transfer vets from one health care facility to another in order to continue ongoing VA care.

The new policy discriminates against veterans who live in rural areas. Many veterans in my district are on the fringe of the 100-mile radius limitation and must travel a long way to receive care. Such a policy forces them to forego needed examinations, treatment and other required care simply because they cannot afford the cost of travel.

The beneficiary travel program only defrays a part of the cost the veteran incurs while traveling to and from scheduled appointments. I'm confident we all agree that most veterans who use VA services need low-cost medical care. Reducing travel benefits would deny them this necessary care.

We must keep our promises to our veterans by restoring payments to:

*Service-connected veterans for treatment of their disabilities;
*Service-connected vets who are disabled 50% or more for treatment of any disability;
*Veterans who receive a VA pension;
*Low income vets who do not have an annual income exceeding the maximum annual amount of a VA pension;
*Veterans needing special mode transportation;
*Other persons who the VA deems to be unable to afford transport, or who for other reasons should be provided transportation.

We know that most of these veterans live on fixed budgets. Denying transportation allowance for these Americans would seriously hinder their ability to seek necessary medical care.

We must reaffirm our desire to fairly treat our Nation's veterans.

STATEMENT OF

JAMES N. MAGILL, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

VARIOUS LEGISLATIVE PROPOSALS AFFECTING THE VETERANS ADMINISTRATION'S DEPARTMENT OF MEDICINE AND SURGERY

WASHINGTON, D. C. MAY 20, 1987

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

Thank you for the opportunity to appear before this distinguished Subcommittee to express the views of the Veterans of Foreign Wars with respect to several pieces of legislation affecting the Veterans Administration's Department of Medicine and Surgery. At the outset, I would like to commend this Subcommittee for its continuing concern for the medical care provided our nation's veterans. The Chairman and Ranking Minority Member of the full Committee have introduced the following bills by request.

H.R. 2001, provides for the extension of the adult day health-care program and authorizes contract halfway house care for veterans with chronic psychiatric disabilities. Since 1985, the VA has been furnishing adult day health-care and this program is due to expire on September 30, 1988.

Another provision of H.R. 2001 authorizes the VA to establish a pilot program to provide contract treatment in halfway houses, therapeutic communities, psychiatric residential treatment centers and other community-based treatment facilities for any eligible veteran who is suffering from a chronic psychiatric disability. The VFW believes, in many cases, veterans are being discharged from VA facilities with no one to assist them in their home recovery period. The VFW supports the provisions of H.R. 2001.

H.R. 2002 would amend 38 USC to authorize the Administrator of Veterans Affairs to provide on-call pay to certain civil service health-care personnel. Currently, the VA must place health-care support personnel such as X-ray, laboratory, operating room and other technicians in a "standby" duty status to ensure they would be available if a medical emergency should arise and to pay them "standby" duty premium pay whether they actually work or not. Those employees in an "on-call" status are not required to be at their assigned duty stations but must arrange for others to respond to a call or leave a telephone number where they may be reached. Employees who are "on call" do not receive pay; however, if called back to work they do receive overtime pay for the time they actually worked.

H.R. 2002 would provide "on call" pay at a rate equal to ten percent of the hourly overtime rate. The VFW believes this bill not only brings equity to the Title V and Title 38 pay schedules for VA health-care employees but, it is our understanding, will result in a cost savings. As a result, the VFW supports H.R. 2002.

H.R. 2003 would authorize the Chief Medical Director to waive state licensure requirements for registered, practical or vocational nurses and physical therapists not to be employed in patient care and for licensed or vocational nurses and physical therapists to be employed in a foreign country. Under current law, health-care professionals must be licensed or registered in a state in order to be eligible for appointment in the VA's Department of Medicine and Surgery.

It is our understanding the primary intent of this legislation is to promote the VA's medical research and education programs by allowing the Chief Medical Director to appoint nonlicensed professionals to research or academic assignments. It is also our understanding these individuals would not be involved in any patient care.

The bill would also waive the state licensing requirement for licensed or vocational nurses and physical therapists to be employed in a foreign country. The only foreign country where the VA currently has a health-care facility is in Manila, the Philippines. H.R. 2003 would not require a VA health-care appointee to be state licensed when only practicing his or her profession in the Philippines. The VFW supports H.R. 2003.

H.R. 2004 would clarify the authority of the Chief Medical Director or his designee regarding disciplinary actions for certain probationary Title 38 health-care employees. This bill would simply clarify the intent of Congress that the Administrator has the power to prescribe by regulation the procedures to be followed by the Professional Standard Boards, circumstances in which Board proceedings may be initiated and that final action in the review process should be taken by the Chief Medical Director. The VFW supports H.R. 2004.

H.R. 2006, the "Veterans' Health Care Benefits Administration Act of 1987," would generally liberalize the access requirements of eligible veterans to certain health-care facilities. The proposed legislation would allow the VA to pay for emergency care needed by VA patients in private nursing homes in the same manner that it now pays for such care for its patients in VA or other Government facilities; would set a higher index rate in those states without a general hospital (Alaska and Hawaii); would allow the VA to provide health care to non-U.S. citizens who were disabled while serving in the U.S. armed forces during a period of war, primarily a group of approximately 1,200 Canadian citizens who were disabled while serving with U.S. forces in Vietnam; would clarify the VA's authority to provide medical services to veterans participating in a vocational rehabilitation program outside the United States; and, would in certain instances, authorize the VA to contract for hospital admission for observation and examination in order to determine a veteran's eligibility for compensation or pension when the local VA medical center is unable to provide such services.

The VFW believes the provisions of H.R. 2006, again, liberalize eligibility requirements and would only affect a small number of deserving veterans who would otherwise not be eligible for VA health care. Therefore, we support the enactment of H.R. 2006.

H.R. 2007, the "VA Health Care Amendment Act of 1987," would expand the term "nursing home care" to include both skilled and intermediate levels as is now provided by the VA; make domiciliary care eligibility requirements the same for all veterans; allows specific legal authority for the VA to establish off-station therapeutic recreational activities; and, would make an individual disabled by VA treatment, examination or vocational rehabilitation eligible for outpatient care as are service-connected disabled veterans.

It is our understanding this VA initiative is intended to expand eligibility to the domiciliary program as well as the other areas of services provided to veterans; therefore, we support H.R. 2007.

H.R. 2010 would authorize the modification of the structure of the Office of the Chief Medical Director; clarify procedures for removal for cause of certain employees; and authorize the use of the Director Pay Grade within the VA Central Office.

The VFW believes H.R. 2010 will give the Chief Medical Director more flexibility and authority to manage his department. We have no objections with the bill's provision authorizing a maximum of two Associate Deputy Medical Directors. We do, however, have strong reservations with section "B" of the bill which would reduce from eight to seven the number of Assistant Chief Medical Directors. What is particularly distrubing to the VFW is the fact that H.R. 2010 does not specifically require an Assistant Chief Medical Director for Geriatrics and Extended Care. Considering the vital role geriatric care will be playing in the near future we cannot understand why the VA would eliminate this crucial position. While the VFW will not oppose H.R. 2010, we cannot stress strongly enough our recommendation that specific language requiring an Assistant Chief Medical Director for Geriatrics and Extended Care be included in H.R. 2010.

H.R. 2146, introduced by Congressman Lane Evans, would extend the transition period for the Veterans Administration readjustment counseling centers program.

This bill would extend the Vet Center program for one additional year and require that the transition from "storefront" to "VA in-house" be accomplished by October 1, 1990. We further note that this bill would require the VA to maintain the number of Vet Centers in operation as of April 1, 1987 until October 1, 1988.

The VFW has long supported the Vet Center program and we encourage favorable action on this bill. The large numbers of veterans utilizing this valuable program attest to its being extended.

H.R. 2327 would amend Title 38, United States Code, to ensure eligibility for beneficiary travel benefits to certain individuals. This bill, introduced by the Honorable Gerald Solomon, Ranking Minority Member of the House Veterans' Affairs Committee, enjoys the cosponsorship of over 100 members of Congress. This piece of legislation would require the Veterans Administration to provide beneficiary travel to service-connected disabled veterans, veterans receiving nonservice-connected pension and those veterans whose annual income is judged too low to be able to defray the expense of travel to VA health-care facilities.

The Veterans of Foreign Wars, at out most recent National Convention, adopted Resolution Number 619 entitled "Beneficiary Travel." While this resolution, a copy of which is appended to my statement, goes further than what is provided for in H.R. 2327, the VFW nevertheless commends Mr. Solomon for introducing this much needed legislation. H.R. 2327 is a step in the right direction and the VFW supports its enactment.

Finally, we were asked to comment on a draft proposal submitted by the Chairman of the House Veterans' Affairs Committee intended to improve health-care programs of the Veterans Administration.

The draft legislation before us makes several technical amendments designed to reflect in Title 38 recently enacted legislation. The proposal also would allow the Veterans Administration to extend nurses premium pay for an entire weekend; transfer pharmacist pay schedule authority from Title V to Title 38; grant the Administrator the authority to appoint disciplinary boards; liberalize the VA's Health Profession Scholarship Program; and, exclude temporary research personnel of the Veterans Administration from any ceiling on full-time equivalent employers. The VFW supports these legislative initiatives.

Section 9 would establish a pilot program to allow certain VA medical center directors flexibility in the management and administration of their individual medical center. The goal of this program is to find new and innovative ways of improving the efficiency and economy of the medical center. The VFW applauds this attempt to discover new progressive ways of improving the VA medical center's operations.

Section 10 would give authority to conduct a pilot program aimed at helping homeless veterans who are chronically mentally ill. As you know, the VFW has often testified on behalf of the homeless veteran. All available statistics suggest that a large segment of the homeless population are veterans and it has been noted many are homeless because of chronic mental illnesses. The VFW supports this pilot program which would provide care and treatment and rehabilitative services in halfway houses, therapeutic communities, psychiatric residential treatment centers and other community-based treatment facilities.

This concludes my statement. Again, the VFW appreciates the opportunity to come before this distinguished Subcommittee to present our views. I will be happy to respond to any questions you may have.

STATEMENT OF
DAVID W. GORMAN
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
FOR MEDICAL AFFAIRS
DISABLED AMERICAN VETERANS
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
HOUSE COMMITTEE ON VETERANS AFFAIRS
May 20, 1987

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the more than 1.1 million members of the Disabled American Veterans and its Ladies' Auxiliary, I am pleased to have the opportunity to appear here today to discuss various issues relating to the Veterans Administration's health care system.

Your letter of invitation requested our testimony regarding draft legislation which would:

1. require that the VA shall provide outpatient medical services to veterans eligible for needed hospital care under "Category A" criteria;

2. link eligibility for VA domiciliary care to inability to defray expenses of such care;

3. modify procedures for disciplinary boards;

4. expand eligibility for the Health Professional Scholarship Program to occupations included in Section 4104 of Title 38, United States Code;

5. establish a pilot program on hospital management efficiency; and

6. include pharmacists under the Title 38 personnel system for appointment and pay purposes, similar to the status of physical therapists, as established by Public Law 98-160.

In addition, our testimony was solicited relating to H.R. 2001; H.R. 2002; H.R. 2003; H.R. 2004; H.R. 2006; H.R. 2007; H.R. 2010; H.R. 2146 and H.R. 2327

Mr. Chairman, the DAV applauds your efforts in proposing legislation that would amend Section 612(a)(1), Title 38, USC, mandating the VA to provide outpatient medical services to veterans eligible for hospital care under the provisions of Section 610(a)(1)...so-called "Category A" veterans.

As you know, "Category A" veterans are specifically defined as:

* veterans seeking care for a service connected disability;

* veterans whose discharge or release from the active military service was for a disability incurred or aggravated in the line of duty;

* veterans disabled as a result of VA medical treatment or vocational rehabilitation (Section 351, Title 38, United States Code);

* veterans rated 50% or more for service connected disability(ies);

* veterans who have a service connected disability;

* veterans who are former prisoners of war;

* veterans exposed to certain herbicides (Agent Orange) or Ionizing Radiation;

* veterans of the Spanish American War, Mexican Border Period or World War I; and

* nonservice-connected veterans who are determined unable to defray the expenses of necessary medical care.

Current law stipulates that outpatient services will be provided in more limited circumstances than inpatient hospital care. Additionally, and of great concern to the DAV, is the discretionary language of Section 612 wherein the "Administrator may furnish such medical services (outpatient care) as the Administrator determines are needed."

All veterans deemed eligible for outpatient care may very well be denied such care if VA facilities are deemed not available to provide such care.

Mr. Chairman, the very same logic employed in enacting Public 99-272, "The Consolidated Omnibus Budget Reconciliation Act of 1985," mandating the VA to provide hospital care to specifically defined categories of veterans, holds true when we consider the dilemma eligible veterans now face based on the discretionary authority that the Administrator "may" provide outpatient medical services.

Therefore, this proposal, Section 2 of the draft bill, has the full support of the DAV.

Section 3 of the draft legislation would amend Section 610(b) to read, "The Administrator, within the limits of Veterans Administration facilities may furnish domiciliary care to a veteran who is in need of domiciliary care if such veteran is able to defray the expenses of necessary domiciliary care."

As we understand it, this measure would effectively remove the rather rigid and restrictive eligibility requirements concerning a service-connected disabled veteran seeking admittance to a VA domiciliary. With this restriction removed, we view Section 3 as beneficial to service-connected disabled veterans and, therefore, support its enactment.

However, so as to further clarify a service-connected disabled veteran's eligibility for domiciliary care, regardless of annual income, we suggest that Section 622(a)(1) be amended to read, "...Section 610(a)(1)(I) and 610(b) of this title...."

Mr. Chairman, in our view, a service-connected disabled veteran's eligibility for VA health care, inclusive of those unique services provided in a domiciliary setting, should not be predicated, in any way whatsoever, on the veteran's annual income.

Therefore, we request careful consideration be given to our proposed amendment.

Mr. Chairman, in reference to Section 5 of the draft legislation, the DAV fully supports those amendments that would include pharmacists under Title 38, USC, for appointment and pay purposes, as well as provide additional pay for registered nurses who work on Saturdays.

The DAV favors enactment of Section 7 which would expand the eligibility for the Health Professional Scholarship Program to those occupations included in Section 4104 of Title 38, United States Code.

Mr. Chairman, Section 9 proposes to establish a pilot program, within the Veterans Administration's Department of Medicine and Surgery (DM&S), for the express purpose of determining the potential efficiency and economy of the management of VA medical centers.

As constructed, this proposal would direct the Administrator to designate five (5) medical centers to participate in the pilot program. The directors of the designated medical centers would be authorized to waive or alter laws and regulations that would otherwise be applicable to the management and administrative functions of the medical center.

As we understand it, Mr. Chairman, all laws and regulations relating to eligibility of veterans to receive needed VA medical services would remain intact and not be subjected to discretionary waiver or modification by the medical center director.

Our reading and interpretation of this draft measure would limit the director's authority to waive or alter laws and regulations only as they may apply to existing constraints or specific limitations imposed by Congressional directives and actions.

Mr. Chairman, so long as otherwise eligible veterans -- especially service-connected disabled veterans -- are not denied or forced to postpone needed medical treatment and/or services, we have no objection to enactment into law of this proposal.

We feel it vital, however, that a clear explanation of the intent of this measure -- to remove certain Congressional constraints on management and administrative functions -- be contained in report language so there will be no room for doubt or controversy regarding veterans' continued eligibility under existing law and regulation for the provision of needed medical services.

Section 10 would mandate the Administrator to conduct a pilot program to provide care, treatment and rehabilitative services, by contracts, in halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community based treatment facilities to homeless veterans suffering from chronic mental illness disabilities who are also eligible for VA hospital care. Funding would be authorized in Fiscal Year 1988 for the sum of $6 million to conduct this program.

Mr. Chairman, the DAV is very concerned regarding the issue of homeless veterans and, therefore, have no serious objections to this measure.

We do, however, feel that the use of underutilized or unused VA facilities by the VA for providing shelter is a viable and readily attainable proposal. We know that there are many such buildings situated on medical center grounds that could be adapted and used as a logical extension of the VA domiciliary program. Additionally, state veterans homes should not be overlooked as a potential source of providing temporary residence.

Section 10(d) requires the submission of reports on homeless veterans and chronically mentally ill veterans. In our view, these reports will result in the compilation of data that

will enhance the government's knowledge, efforts and ability to assist these veterans.

Mr. Chairman, it is our belief that the VA has been providing and will continue to provide significant assistance to homeless veterans via existing programs and authority...specifically: benefit counseling, the provision of various health care services, and the extension of monetary entitlements (nonservice-connected pensions) to indigent veterans and their families.

As we envision it, trained veterans' benefits counselors are ideally equipped to provide a vast array of services, as would existing professional health care personnel. The VA should be permitted and encouraged to do what they do best. Existing community resources are perhaps in the best position to provide shelter and food. Where this may not be possible, appropriate utilization of VA facilities, as discussed earlier, may prove to be an appropriate means of providing temporary shelter and subsistence.

While we do not object to enactment of this proposal, we encourage and urge the VA to also move forward in an expeditious manner to expand the domiciliary program to a level sufficient to provide the services necessary to homeless veterans.

The DAV has no official position regarding Sections 4, 6, or 8, of the draft bill.

H.R. 2001

The DAV supports H.R. 2001, which proposes to extend the VA's authority for providing adult day health care for three years until September 30, 1991.

H.R. 2002

This measure proposes, by appropriate amendment to Section 4107, Title 38, United States Code, to provide "on call pay" to civil service health care employees appointed pursuant to Title 5, United States Code, or Section 4104(3), Title 38, United States Code.

As we understand it, Mr. Chairman, cost savings will occur by providing "on call pay" instead of the more expensive "stand by pay" currently required to be furnished those Title 5 employees. Because of this and the feeling that patient care will not be placed in jeopardy, we are able to support this measure.

H.R. 2003

Introduced by yourself, Mr. Chairman, this measure would amend Section (d) of Section 4114, Title 38, United States Code, to authorize the CMD to waive state licensure requirements for registered, practical or vocational nurses and physical therapists not to be employed in direct patient care, and for licensed or vocational nurses and physical therapists to be employed in a foreign country.

The DAV has no mandated position on this measure.

H.R. 2004

This measure proposes, by appropriate amendment to Section 4106(b), Title 38, United States Code, to clarify the authority of the CMD or designee regarding disciplinary actions on certain probationary Title 38 health care employees.

We have no official position regarding this measure.

H.R. 2006

This measure, introduced by yourself, Mr. Chairman, seeks to amend Title 38, United States Code:

* Section 603(a)(3) authorizing the VA to provide emergency hospital care in private facilities for veterans receiving VA sponsored (contract) nursing home care in facilities geographically distant from VA medical centers;

* Section 603(a) by adding a new paragraph authorizing the VA to contract for care for a veteran deemed to require a period of hospitalization for the purpose of observation and examination to determine eligibility for a VA benefit.

* Section 620(a)(2) providing a higher per diem rate for providing VA sponsored care in Alaska and Hawaii, helping to assure the VA's ability to provide such care; and

* Section 624(b) deleting the citizenship requirement in order to receive VA health care services.

Mr. Chairman, although the DAV has no official position relating to this measure, we are supportive of its enactment.

H.R. 2007

Introduced by yourself, Mr. Chairman, this measure would serve to revise and clarify the VA's authority to furnish certain health care benefits.

H.R. 2007 proposes the following amendments to Title 38, United States Code:

* Section 101(28) -- to clarify the statutory definition of the term "nursing home" to include both skilled and intermediate levels of care;

* Section 601(4) -- to establish specific legal authority to provide patients receiving VA health care services with off-station recreational activities;

* Section 610(b) -- clarifying the authority to provide domiciliary care; and

* Section 612(a)(1) -- permitting outpatient treatment to veterans in receipt of compensation payments, under Section 351, for the disability for which the compensation is being received.

The DAV has no opposition to enactment of H.R. 2007.

H.R. 2010

Mr. Chairman, this measure would amend Section 4103 of Title 38, United States Code, relating to the organization and composition of the Office of the Chief Medical Director (CMD) to allow for the establishment of a new position -- a second Associate Deputy Chief Medical Director (ADCMD) -- and provide flexibility in other appointments within that office.

The DAV has no objection to any action that would permit the CMD greater flexibility in the day-to-day operations of the Department of Medicine and Surgery. So long as direct patient care is not jeopardized, we could support this measure.

However, Mr. Chairman, we have rather serious concerns regarding the removal of the requirement that the position of Assistant Chief Medical Director (ACMD) for Geriatrics be a qualified physician trained, or having suitable extensive experience, in geriatrics.

As we are all only too well aware, one of the most challenging issues facing the VA today is how the agency will respond to the future health care needs of the ever-increasing older veteran population.

Mr. Chairman, the VA is certainly not alone in searching for ways and methods to meet the health care needs of older Americans. On the contrary, joint cooperative efforts must be explored and launched with many other federal, as well as community, agencies. To this end, consideration must be accorded to a wide range and variety of other medical disciplines. It is our view that in order to maximize the Agency's efforts in this area, the responsible ACMD must be a qualified physician.

Therefore, we suggest amending the pertinent part of H.R. 2010 to retain the requirement that the ACMD for Geriatrics be a qualified physician.

H.R. 2146

Mr. Chairman, H.R. 2146 would, in essence, provide for the delay of the date on which the two year "transition period" of the Vietnam Veterans Readjustment Counseling Program is to begin -- from a program providing such services primarily through centers located in facilities situated apart from the health care facilities operated by the VA to a program providing readjustment services primarily through VA operated health care facilities.

Additionally, this measure would provide for the delay in the due dates of the three separate reports required by Section 612A(g), Title 38, United States Code.

These consist of:

1. A report, due by April 1, 1987, which would state the Administrator's evaluation of the VA's effectiveness in meeting the readjustment needs of Vietnam veterans and his opinion as to the feasibility of moving forward with the transition effort;

2. A report, due by July 1, 1987, setting forth a plan and timetable for accomplishing the transition; and

3. A report, due by February 1, 1989, setting forth the VA's experience during the initial period of the transition process.

Mr. Chairman, the intent of this measure is clear when one considers the considerable difficulties the VA has encountered in attempting to "get off the ground" a comprehensive study relating to post-traumatic stress disorder (PTSD). This mandated study was designed to identify the prevalence and incidence among Vietnam veterans of PTSD -- as well as other post-war psychological problems in readjusting from their military service.

It is unfortunate and very discouraging that the VA and Research Triangle Institute, Incorporated -- contracted to conduct the study -- have permitted the timetable to complete the study to be severely delayed. Without belaboring the issue, it is our understanding that the final report of the study will

not be completed until December, 1988, a full two years behind the original due date.

Mr. Chairman, the DAV has continually expressed our commitment toward assisting Vietnam veterans suffering psychological problems associated with their military service. As you know, the DAV provided funding as early as 1976 for "The Forgotten Warrior Project" a study which lead, in October, 1978, to the DAV initiating our Vietnam Veterans Outreach Program. We feel it was, in large part, due to our efforts that the VA created their current network of Vet Centers.

We believe this program has been and will continue to be utilized by veterans of the Vietnam Conflict. However, we wish to reiterate our strong support for the concept that the VA must move forward to integrate these services into the mainstream of traditional and existing VA health care facilities -- VA medical centers.

Mr. Chairman, in view of the fact that the comprehensive PTSD study is required by law to be used in preparing the reports relative to the transition process, and because it is clear that the Administrator will not have the benefit of the study results for the preparation of the report due by April 1, 1987, and, if a consensus is reached that the results of the PTSD study are vital and necessary to formulate the various transition reports, we would not object to the enactment of this legislation.

We do, however, wish to state our disappointment regarding the delays that have occurred because of the apparent flaws in the study's design. Also, we would strongly urge the VA to do everything possible to move swiftly to insure the completion of this vital study. To do less would not be in the best interests of Vietnam veterans.

Mr. Chairman, the DAV objects to that portion of H.R. 2146 that proposes to mandate "The Administrator shall maintain in operation until October 1, 1988, the same number of readjustment counseling centers as were in operation on April 1, 1987."

The Agency has identified a number of "Vet Centers" for relocation from community based operations to ones that provide services on VA medical center grounds. Full justification has been documented for the "Vet Centers" concerned and this action is certainly in concert with the stated intent of Congress.

Any Congressional action to impede this sound and orderly transition would, in our view, create an unwarranted encroachment on the Administrator's ability to effectuate action to enhance the efficiency of the Readjustment Counseling Service.

H.R. 2327

Mr. Chairman, the DAV is pleased to have this opportunity to address H.R. 2327, introduced by the distinguished Ranking Minority Member of this Committee and yourself, that would insure eligibility of certain individuals for beneficiary travel benefits when travelling to Veterans Administration medical facilities.

The DAV applauds the authors of this measure, as well as the some 160 members of the United States House of Representatives who have thus far cosponsored this bill.

As you know, Mr. Chairman, in anticipation of the elimination of the beneficiary travel payment, the DAV, during December 1986, initiated one of the most comprehensive and

ambitious service efforts ever undertaken by our organization -- the DAV Transportation Network -- a nationwide program to provide transportation services to veterans in need of medical care at VA facilities.

The DAV Transportation Network was developed in cooperation with VA Central Office officials, and is designed to operate as a fully integrated service within each VA medical facility. To accomplish this, in part, a full time DAV Hospital Service Coordinator is to be placed at each of the VA's 172 medical centers.

We are pleased to report, Mr. Chairman, that in less than five months since the inception of this program 42 VA medical facilities have full time DAV Hospital Service Coordinators in place, with many more scheduled to come online during the remainder of this year.

The DAV is committed to fully serving this nation's veterans and will continue to do so through this program, as well as our other DAV programs and services.

Obviously, the task is enormous and the virtual elimination of the VA's beneficiary travel program will, in fact, serve to deny some veterans access to needed VA health care services, until such time as the DAV's Transportation Network is fully in place.

As we understand it, H.R. 2327 would amend Section 111, Title 38, USC, to mandate the Administrator to provide eligible veterans with necessary travel expenses when seeking VA medical care.

Eligible veterans are defined as:

* a veteran travelling in connection with treatment of a service-connected disability;

* a veteran with a service-connected disability rated at 50% or more, for any disability;

* a veteran receiving or eligible to receive pension under Section 521 of Title 38, for any disability;

* a veteran whose annual income (as determined in accordance with Section 503 of Title 38, USC) does not exceed the maximum annual rate of pension which would be payable to such veteran if they were eligible for pension under Section 521 of this Title, for any disability;

* a veteran for whom ambulance transportation, wheelchair van transportation or other special mode of transportation is medically indicated and an administrative determination is made that the veteran is unable to bear the cost of such for any disability;

* a veteran who is determined (under regulations prescribed by the Administrator) to be unable to defray the expenses of the travel for which payment under this section is claimed, for any disability; and

* such other persons as the Administrator determines by regulation.

Mr. Chairman, while the DAV is certainly supportive of and appreciates the inclusion of the above mentioned veterans for entitlement to beneficiary travel payments, we are, nevertheless, concerned that an equally deserving category of

veterans has been excluded from eligibility -- any service-connected disabled veteran.

As you are aware, the VA contracted with MAXIMUS, Incorporated, to conduct a study of the beneficiary travel program and the final report and analysis was completed during March, 1985.

The MAXIMUS report delineates many salient facts integral to the beneficiary travel program then in effect:

* 71% of program users were service-connected disabled veterans and 29% were nonservice-connected veterans;

* program users were more likely to be unemployed or retired than were non-users;

* more program users had incomes below $10,000 than did non-users;

* program users were more likely to have been admitted to a VA hospital during the previous 12 months than were non-users;

* program users were more likely to have had more than 20 outpatient visits to VA facilities in the previous 12 months than were non-users; and

* program users travelled greater distances to reach the VA for health care than did non-users.

MAXIMUS also assessed the contributions of the program in maintaining access to the VA for needed health care and found that a full 35% of veterans interviewed stated they would have been unable to use the VA if they had not received beneficiary travel.

An analysis of the characteristics of users of the program who stated they needed the travel benefit to maintain access to the VA for health care showed they were most likely to be:

* veterans with an annual income below $5,500;

* veterans who were unemployed or retired;

* veterans who traveled by hired car or taxi; and

* veterans who had more than four hospital admissions or more than 100 outpatient visits to VA health care facilities during the 12 months preceding the interview.

It appears clear, therefore, that service-connected disabled veterans who are probably unemployed/retired, have marginal incomes, are frequent users of the VA health care system and travel great distances to receive health care could, in large part, continue to be denied access to the system if beneficiary travel is not available to them.

Mr. Chairman, we are of the firm conviction that assistance must be provided to disabled veterans to insure their ability to access the VA health care system if their medical needs are to be met. Without such assistance, innumerable numbers of veterans will be forced, for lack of any recourse, to forego their health care needs which we view as totally unacceptable.

It is, therefore, our view that in order to maintain the often-cited intent of providing, to the fullest extent possible,

VA health care services to the most deserving veterans, service-connected disabled veterans and low income veterans, that appropriate amendment be made to H.R. 2327, to include any service-connected disabled veteran in the list of eligible veterans to receive this vital benefit.

Mr. Chairman, after relating our views for the need for such an amendment and hopeful of its inclusion in the bill, the DAV fully embraces the provisions of this measure and urge it be acted upon in the most expeditious manner possible.

That concludes our statement, Mr. Chairman. We wish to again thank you and the members of the Subcommittee for allowing us the opportunity to present the views of the DAV on these important issues.

PARALYZED VETERANS
OF AMERICA

Forty Years of Service
1947-1987

STATEMENT

OF

FRANK R. DEGEORGE, ASSOCIATE LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

OF THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

REGARDING

"VETERANS' ADMINISTRATION HEALTH-CARE AMENDMENTS OF 1987"

BENEFICIARY TRAVEL, AND VARIOUS OTHER VETERANS ADMINISTRATION

HEALTH-CARE RELATED ISSUES

MAY 20, 1987

Mr. Chairman and Members of the Subcommittee, on behalf of the members of Paralyzed Veterans of America, a congressionally chartered veterans' service organization, I want to thank you for this opportunity to present our views

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Chartered by the Congress of the United States

regarding a package of various legislative health care proposals. I am Frank R. DeGeorge, Associate Legislative Director.

PVA appreciates the Subcommittee's responsible efforts to conduct this important hearing regarding improvements in related VA health-care programs.

"VA HEALTH-CARE AMENDMENTS OF 1987"

This draft bill would amend or repeal certain sections or provisions of Title 38, United States Code. PVA provides the following comments addressing each issue significant to our membership in a section by section analysis.

SEC. 2. ELIGIBILITY FOR MEDICAL SERVICES.

PVA agrees with the amendment to Section 612 (a)(1) to insert: "shall furnish such medical services as the Administrator determines are needed to any veteran entitled to hospital care under Section 610 (a)(1) of this title." This section, as amended, would provide VA outpatient treatment as an entitlement to veterans as defined eligible under category "A". PVA endorses the purpose and intent of this amendment.

PVA testified earlier that under current law, "Category A," certain nonservice-connected veterans may also receive outpatient treatment when it obviates the need for inpatient care, is a follow-up to an episode of inpatient care, or, according to the VA, "if space is available." There is considerable latitude in the exercise of the VA physician's judgment regarding the interpretation of "to obviate the need" for hospitalization.

The recent marked reduction in VA inpatient census and length of stay is primarily dollar driven, stemming from the imposition of DRG-based resource distribution and decremental budgets. Similarly it appears that outpatient care to obviate the need for hospital admission is now more restrictively granted. PVA believes from the position of continuity of care, as well as continuity with other federal health programs, that outpatient services for "Category A" veterans should be made an entitlement.

Particularly for the chronically ill, medically indigent veteran whose disability is not service-connected, lack of clear access to outpatient services can be most unfortunate, if not dangerous. Such a patient may have the need for ongoing close medical supervision only to be told that hospitalization is not necessary and therefore VA-furnished outpatient care is not available.

Couple this situation with the current restriction in beneficiary travel allowances, which will further limit a veteran physical access to a VA health care facility, and the potential for medical crisis looms great, particularly for older chronically ill veterans. The veteran is likely to have no other means of access to care unless he or she also qualifies for Medicaid. The Medicaid patient, incidentally, is provided ambulatory care regardless of inpatient care need -- an arrangement certainly more cost effective than inviting, through patient neglect, a crisis need for hospitalization. However, Medicaid is not an alternative for most indigent veterans under 65 because they do not meet its categorical eligibility requirements. If they are unable to access the VA system, these veterans are likely to add to the

uncompensated care burden that providers are increasingly shunning or to fail entirely to obtain care when it is needed.

The VA health care system has always been distinguished for its ability to provide certain patients a comprehensive, coordinated continuum of care. It is regrettable that P.L. 99-272 did not endorse that concept in the course of realignment of entitlement for "Category A" nonservice-connected veterans. Unrestricted outpatient care for all "Category A" veterans would make for a better quality of care, simplify administrative management, encourage preventive care, reduce the incidence of acute complication, and -- in the last analysis -- better serve cost containment. Indeed the Congressional Budget Office, in the analysis of the original version of P.L. 99-272, which included full outpatient entitlement, judged it to be a cost saving legislative proposal.

Most recent data of VA usage under the eligibility reforms (P.L. 99-272), signed into law in April 1986, indicate that 94.1% of 931,000 applications for health care received by the VA through February 11, 1987, fell into the highest eligibility category for care, "Category A", which includes veterans with service-connected disabilities, certain veterans with special eligibility, and non-service-connected disabled veterans with incomes under $15,000 per year.

These statistics clearly prove the role the VA plays in providing health care services to a deserving and in many cases near-medically indigent patient population. PVA believes it is vital to weigh the immense contribution of the VA within the overall national health care mission in providing acute

care and long-term care to millions of senior American veterans. In this sense, the cost and contribution of the VA should be counted as a national asset.

SEC. 3. DOMICILIARY CARE.

This section would extend authorization to provide "domiciliary care to a veteran." PVA believes that expanding the eligibility provisions of this program will, in part, address the plight of homeless veterans needing shelter and medical support, assist veterans under "Category A" status, and in the future provide institutional care for certain older veterans.

PVA supports this effort. However, PVA believes that in order to be consistent with other VA health-care eligibility requirements that veterans with service-connected disability receive priority for domiciliary care.

PVA supports the provision contained in the House Committee on Veterans' Affairs report dated February 25, 1987, which recommends that $15 million be added to the Administration's budget request for the purpose of expanding the VA's capacity to provide domiciliary care in urban locations. The Committee report further recommended that the VA plan to open approximately 600 new domiciliary beds in no less than 10 urban locations by using $7.5 million of the $15 million for emergency, non-recurring maintenance projects at such facilities.

PVA applauds the Subcommittee's consideration and its approach to initiate and expand the VA's Domiciliary care program.

SEC. 5. MISCELLANEOUS MEDICAL PERSONNEL MATTERS.

(a) NURSES PREMIUM PAY.

This section is designed to provide VA nurses with weekend premium pay for weekend duty which occur on a Saturday or Sunday. PVA strongly supports such measures designed to enhance the recruitment and retention of VA nurses. This policy is also consistent with weekend premium differentials which are common in non-VA hospitals, thereby allowing the VA as a employer to become more competitive. PVA would support expansion of weekend pay differential to all allied health care personnel as well, including licensed practical nurse and nursing assistants.

(b) PHARMACISTS.

This provision adds pharmacists to the Title 5/Title 38 hybrid personnel group. PVA believes that this personnel re-grouping will give the VA greater flexibility in hiring practices and setting pay rates for this group of health professionals already identified in the 1986 VA Health Occupational Survey to be experiencing severe shortages. PVA supports this provision as a necessary retention and recruitment technique. We would also support expansion of the Title 5/Title 38 employment group to also include occupational therapists.

SEC. 7. COURSES OF TRAINING FOR HEALTH PROFESSIONS SCHOLARSHIP PROGRAM.

PVA supports and applauds the efforts of this Subcommittee to expand the Health Professions Scholarship Program. We have previously testified that not only should this important program be expanded to other critically needed health professionals, but that this program be fully funded this year and also be made permanent. To PVA there is no surer way to breed discontent among employees than to promise a particular benefit upon employment only to refuse that same benefit in the future. The VA as an employer needs to provide a degree of certainty when offering its benefits package to potential applicants. The uncertainty surrounding the funding of this critical program from year to year creates confusion and false assumptions on the part of the applicant.

SEC. 8. PERSONNEL CEILINGS FOR NONCAREER RESEARCH PERSONNEL

PVA is pleased to support this provision which excludes temporary research personnel from any ceiling on VA full time equivalent employees. We believe that, as the name implies, these employees are temporary and fall into a different category from regular VA employees in terms of funding and function. Any attempt to count them as regular VA employees will further limit the already restricted numbers of authorized health care personnel at individual medical centers available for patient care and research.

SEC. 9. PILOT PROGRAM ON HOSPITAL MANAGEMENT EFFICIENCY

This section would authorize the Administration to carry out a pilot program designating five VA medical centers as test sites to conduct management efficiency programs. The provision would give designated medical center

directors the flexibility to waive or alter certain laws and regulations governing the management and administration of their centers in order to tailor individual fiscal and management policy to site-specific needs. PVA is fully aware of the unique mission and operation of each of the VA's 172 medical centers. Undoubtedly, national regulations governing the administration of a national health care system as diverse as the VA could at times interrupt or hamper the efficient management abilities of an individual medical center director attempting to meet specific changing needs at his or her facility.

We believe the pilot programs could be useful in identifying areas where the proper administrative flexibility could be given to a station director to promote management initiative, improved efficiencies in service and potential cost savings to the VA. In supporting this provision, however, we would caution the Subcommittee to insure that any waiver of regulation granted to a medical center director, and any resulting efficiency, should not be construed at either the local or the central office level as an open invitation to restrict budgets and services to veterans. Any such efficiencies should be made and used for the enhancement of the quality and quantity of care. While this section does specifically address the preservation and protection of the facilities' budget, we believe that the Subcommittee should underscore the point that any localized waiver of national management regulations at 5 of the 172 VA Medical Centers should be closely monitored to avoid any inconsistency with existing health care eligibility requirements and general administrative practices established by law and regulation common to the entire VA Medical system.

SEC. 10. CONTRACT COMMUNITY-BASED RESIDENTIAL CARE

PVA supports this provision which calls for a pilot program to provide non-institutional contract care, treatment, and rehabilitative services in halfway houses, therapeutic communities and psychiatric treatment centers for homeless veterans. We believe the program can benefit the significant numbers of homeless veterans currently suffering from untreated chronic psychiatric disorders. The program can also provide an additional community-based treatment methodology for veterans facing discharge from VA psychiatric facilities who could become homeless without any other means of transitional treatment and access to support programs to meet their physical and mental health care needs.

We believe the Subcommittee has found, if properly controlled and maintained, a concept, which, along with the expansion of eligibility for domiciliary care and other initiatives, will add to the VA's "tool chest" in caring for the growing numbers of homeless veterans in the United States today.

H.R. 2002 To amend Title 38, United States Code, to authorize the Administrator of Veterans' Affairs to provide on-call pay to certain civil service health-care personnel.

PVA supports this measure which will make consistent, the methods and payment of "on-call" duty for all health care professionals in the VA. We believe

that the authority to provide on call duty in emergency situations is necessary to provide 24 hour medical care to our nation's veterans.

H.R. 2003 To amend Title 38, United States Code, to authorize the Chief Medical Director to waive State licensure requirements for registered, practical or vocational nurses and physical therapists not to be employed in patient care, and for licensed or vocational nurses and physical therapists to be employed in a foreign country.

While PVA understands the intention of this measure, we have reservations regarding any measure that would allow the waiver of professional licensure. Many research efforts can or could indirectly involve patient care.

H.R. 2007 To amend Title 38, United States Code, to revise and clarify VA authority to furnish certain health care benefits, and for other purposes.

PVA supports the portion of this measure which clarifies definitions regarding nursing home care to include intermediate as well as skilled nursing care. The statutory definition of nursing home care should be consistent throughout the health care industry to decrease unnecessary confusion. The domiciliary care portion of this measure is addressed elsewhere in our testimony.

H.R. 2146 To extend the transition period for the VA's readjustment counseling centers program, and for other purposes.

PVA supports H.R. 2146 introduced by Representative Lane Evans. The bill would amend Section 612 A (g) of Title 38, United States Code, postponing for one year, the transition period for the VA's Vet Center program.

Due to the fact that the mandated comprehensive study concerning Vietnam veterans and post-traumatic stress disorder has been significantly delayed, PVA finds this extension of the current transition date wholly warranted. The comprehensive study was designed to enable Congress to make informed decisions about the future of the Vet Center Program. Since 1979, the VA has provided counseling for more than 500,000 veterans and family members in Vet Centers. These centers provide referral service as well as counseling for employment, marital, stress-related and other readjustment problems.

PVA believes, that without the Administrator and the Congress having the necessary documentation relevant to the status of Vietnam-era veterans, any planning or transition of Vet Centers should be delayed. We believe the VA should refrain from closing any "storefront" Vet Centers, transitioning their services to VA medical facilities, until the final results of the study are released and thoroughly reviewed. We therefore endorse specific language in H.R. 2146 which states: "The Administrator shall maintain in operation until October 1, 1988 the same number of readjustment counseling centers as well in operation on April 1, 1988."

H.R. 2327 To ensure eligibility of certain individuals for beneficiary travel benefits when traveling to Veterans' Administration medical facilities.

PVA recognizes and commends both the Honorable Gerald Solomon, Ranking Minority Member of the House Committee on Veterans' Affairs and the Honorable G.V. (Sonny) Montgomery, Chairman for their efforts and initiative to introduce this excellent legislation. PVA supports this significant legislation that would restore to a great degree beneficiary travel payments. The bill would restore the benefit to eligible veterans, including certain veterans whose annual income (determined in accordance with Section 503 of Title 38, United States Code) does not exceed the maximum annual rate of pension which would be payable to to such veteran if such veteran were eligible for pension under section 521 of this Title 38, United States Code for disability.

We are hopeful that any future consideration of the bill would extend the benefit to all veterans determined to be in the status of eligibility of "Category A". We believe that such an addition would be wholly consistent with the intent and scope of health care eligibility reforms contained in P.L. 99-272 in providing standardized benefits to all veterans considered to be in the most need.

The VA has changed its regulations on beneficiary travel to drastically curtail eligibility for payment of veterans' travel expenses in connection with receiving VA medical care. The regulations would allow payment only for special-mode transportation and intrafacility transfers and eligible veterans travelling in excess of 100 miles to VA medical facilities.

Previously eligible veterans who must often travel long distances from rural areas to reach the nearest VA medical facility can no longer receive such

payments, even though they may have serious service-connected disabilities. We are concerned that many veterans entitled to receive VA medical care under Public Law 99-272 will be unable to avail themselves of that care, because they will not be able to afford the expense of transportation. This, we believe creates a barrier to health care which could have dire medical consequences for those veterans in most need.

Again, this legislation is praiseworthy. We would like to express our thanks to the over 100 in the members of the House who have cosponsored the legisltion in a major bipartisan demonstration of support.

I would also like to call your attention to a health provision which is an important concern to our membership. It is our hope that Members of the House Committee on Veterans' Affairs will support a legislative provision to provide procreative services to achieve pregnancy in cases involving a service-connected disability causing sexual dysfunction or impairment.

The VA contends that it does not, under current laws have such authority to provide the available medical technologies on behalf of this small group of eligible veterans. Therefore it is necessary to clarify this inconsistency. It seems unconscionable that the VA will provide a veteran compensation for the loss or loss of use of one or more creative organs under Section 314 (k) of Title 38, but will not afford the same veteran access to medical care to mitigate the resultant condition. If this approach was applied in all cases the overall health care provided veterans would be extremely limited and new procedures would seemingly never be applied. Examples are too numerous to list.

The Senate under the leadership of Chairman Alan Cranston has already included a provision to authorize procreative services in S.6, the "Veterans Health Care Improvement Act of 1987." It is our hope that we will also gain the essential support of this Committee on this issue of significant relevance to our membership.

CONCLUSION

Again, PVA appreciates the invitation to appear here today; we applaud the efforts of the Chairman and Members of this Subcommittee to address these issues, and, as well, the dedicated efforts of your staff. I will be happy to answer any questions that I can.

PARALYZED VETERANS
OF AMERICA

Forty Years of Service
1947-1987

June 16, 1987

The Honorable John Paul Hammerschmidt
Ranking Minority Member
Hospitals and Health Care Subcommittee of the
House Committee on Veterans' Affairs
Room 333, Cannon House Office Building
Washington, D.C. 20515

Dear Representative Hammerschmidt:

The Hospitals and Health Care Subcommittee of the House Committee on Veterans' Affairs conducted a hearing on May 20, 1987, addressing legislation, the "Veterans Administration Health Care Amendments of 1987." Mr. Hammerschmidt, you had expressed concerns with provision of Section 2, ELIGIBILITY FOR MEDICAL SERVICES, whereas according to the hearing transcripts you stated and questioned: "Are you advocating that all category 'A' veterans be given full outpatient eligibility as a matter of right, or are you advocating only that current law be changed from 'may' to 'shall' as to current eligibility?" In other words, would you expand, for instance, from the current outpatient eligibility, which is, as you know, treatment for service-connected conditions to treatment for all veterans rated 50 percent or more, treatment to obviate the need for inpatient care, and post hospital care to complete an episode of treatment? My question is, is that what you support, and would you change it from 'may' to 'shall'?"

In response to your request, to reply for the record, the following comment is provided:

On behalf of the Paralyzed Veterans of America, it is our position to support the language change from "may" to "shall." As stated in our testimony, we continue to believe that in accordance with VA health care eligibility requirements veterans with service-connected disability should continue to receive priority for outpatient care, while outpatient treatment is expanded to and assisting veterans within category "A" status. We believe that providing this medical assistance will be a cost saving approach versus other potential alternatives that require unnecessary hospitalization for treatment. Further, as stated in our testimony, from the position of continuity of care as well as continuity with other federal programs, outpatient services for Category "A" veterans should be made an entitlement. Expanding on our testimony, we further believe changing "may to "shall" accomplishes that purpose.

I hope that this answers your concerns and your questions. Thank you for this opportunity to respond for the record.

Sincerely yours,

Frank R. DeGeorge

Frank R. DeGeorge
Associate Legislative Director

cc: G.V. "Sonny" Montgomery, Chairman, House Committee on Veterans Affairs

Opening Statement

HONORABLE MICHAEL BILIRAKIS

May 20, 1987

THANK YOU, MR. CHAIRMAN.

I AM LOOKING FORWARD TO HEARING FROM THE VETERAN COMMUNITY ON THE VARIOUS LEGISLATIVE PROPOSALS BEFORE US TO IMPROVE VA HEALTH CARE. IN LOOKING OVER THE ADVANCE TESTIMONY, IT WAS HEARTENING TO SEE THE DEGREE TO WHICH THE VETERANS' ORGANIZATIONS AGREED ON THE MERITS OF THESE BILLS, AS WELL AS ON THE AREAS OF CONCERN.

CONSENSUS BUILDING AND CLOSE COOPERATION BETWEEN THE CONGRESS AND THE VETERANS' ORGANIZATIONS AND AMONG THE SERVICE ORGANIZATIONS THEMSELVES HAS TRADITIONALLY BEEN A HALLMARK OF THIS COMMITTEE'S WORK, AND I THINK THE NATION'S VETERANS HAVE BEEN WELL-SERVED BY THIS APPROACH.

OF PARTICULAR INTEREST TO ME PERSONALLY IS THE PROPOSAL TO PROVIDE OUTPATIENT CARE AS AN ENTITLEMENT TO CATEGORY A VETERANS. I HAD PRESSED STRONGLY FOR THE INCLUSION OF SUCH A PROVISION IN THE ORIGINAL HEALTH CARE ELIGIBILITY REFORM MEASURE AND WAS DISAPPOINTED THAT IT WAS NOT INCLUDED.

ACCESS TO OUTPATIENT CARE IS PERHAPS THE MOST CRITICAL HEALTH CARE PROBLEM FOR VETERANS IN MY STATE OF FLORIDA AND IT JUST MAKES SENSE TO ENSURE THAT VETERANS WITH THE HIGHEST ELIGIBILITY TO VA HEALTH CARE HAVE ACCESS TO THE WHOLE CONTINUUM OF CARE.

AGAIN, MR. CHAIRMAN, I LOOK FORWARD TO THE TESTIMONY AND APPRECIATE THE OPPORTUNITY TO SHARE MY VIEWS ON THIS ISSUE OF CRITICAL IMPORTANCE TO FLORIDA'S VETERANS.

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STATEMENT OF

MARY STOUT
NATIONAL SECRETARY
VIETNAM VETERANS OF AMERICA

accompanied by

Michael R. Leaveck
Director of Legislative Affairs
and
Richard F. Weidman
Director of Government Relations

Before the

COMMITTEE ON VETERANS AFFAIRS
SUBCOMITTEE ON HOSPITALS AND HEALTH CARE
HOUSE OF REPRESENTATIVES

on

HR 2146
AND MATTERS PERTAINING TO OPERATION OF
VIETNAM VETERAN OUTREACH CENTER PROGRAM

MAY 20, 1987

Mr. Chairman, Vietnam Veterans of America (VVA) thanks you for the opportunity to appear here today to present the views of VVA regarding the delivery of vitally needed health care to our nation's veterans. You asked us to comment on a number of legislative proposals, each of which is important. However, I shall confine our remarks to HR 2146, for reasons of the urgency for immediate action on this proposal. It is our belief that the Office of the Veterans' Administrator is engaged in a headlong and reckless rush to eliminate the Veterans Outreach Centers, by any means necessary, prior to Congress having the opportunity to act in a measured and considered manner to make a decision that, by clearly evidenced intent, is the reserved prerogative of this body.

Vietnam Veterans of America urges the quickest possible passage of this legislation, to avoid irreparable damage to veterans in need of assistance. The so-called "pilot project" to close nine community based Veterans Outreach Centers before the beginning of the Congressionally mandated transition period, due to begin on October 1, 1987, has already set in motion a sequence of events that will be difficult to stop, and will result in significant disruption and impairment of delivery of quality readjustment care and other services in the nine Veterans Outreach Centers targeted for destruction. Once the fabric of services and trust with the veterans currently served (and those whom the Outreach Center is designed to reach out to as future clients) is destroyed, it will be extremely difficult to repair the damage

done.

HR 2146 contains two basic provisions. First, is a one year delay in the beginning of the "transition period" during which the VA is authorized to close a majority of the community based Outreach Centers and relocate the readjustment counseling program into existing VA Medical Centers. Congress mandated several reports to be issued well in advance of the beginning of the transition period in order to determine if the "relocation" concept was viable and acceptable. Unfortunately, those reports have been delayed a full year. This first section of HR 2146 would simply push back the entire calender one year to bring the dates of the transition period into line with the original concept. This proposal has already been approved by the full Senate.

The second provision of HR 2146 simply closes a loop hole that allows the Veterans' Administrator to begin the "relocation" of the Outreach Centers without the consent of Congress--the so-called "pilot program." It is unfortunate that this provision is necessary because the intent of Congress is clear: the commencement of the transition period is set by Congress, not the VA. The Administrator, however, has evidenced both an overt hostility to the Outreach Center program and a blatant disregard for the will of Congress. Thus it has become necessary to legislatively bar the Administrator from violating Congressional intent.

We firmly believe the overwhelming evidence of need warrants the continuation of the delivery of readjustment counseling

services by means of the 188 community based Veterans Outreach Centers, but at the very least it necessitates the delay of the transition period pending further Congressional inquiry and debate.

We also believe a review of the chronology of the extra-legal "pilot program" through which the Administrator's office seeks to close these nine community based Outreach Centers, clearly shows an effort to eliminate the entire Outreach Center program in disregard for and in violation of the intent of Congress. This rushed effort to destroy nine of the community based Outreach Center sites will be contrasted with the chronology of how long it has taken for the Administrator to begin to follow the clear Congressional mandate of Public Law 99-166, which required the creation of ten "Vietnam Veteran Resource Centers." In fact, as this statement makes clear, this Administrator, unless prevented by statute, appears to be determined to close all of the Veterans Outreach Centers that currently exist in communities around the country. The Administrator's claim that this process is a "well conceived orderly process that is not arbitrary" simply does not square with the facts of the matter.

THE NEED

o CDC Study

The Centers for Disease Control, (CDC) in Atlanta recently released a study entitled "Post-Service Mortality Among Vietnam Veterans" which reveals a mortality rate among Vietnam theatre veterans 45% higher than that for "era" veterans who served

elsewhere, during the first five years after service. Most of these deaths were due to "external causes," a category which includes suicides, homicides, motor vehicle accidents and drug overdoses, all of which are deaths which may be readily attributed to emotional trauma related to combat.

In the past ten years, deaths due to "external causes" have declined, but are still significantly higher and there is evidence that drug related deaths are again increasing. We believe the decline is due in large part to the increased availability of intervention and counseling services, most notably the Veteran Outreach Centers.

o Actual Usage

Due to the foresight of Congress, the Veterans Administration has contracted with Research Triangle Institute to conduct the "National Vietnam Veterans Readjustment Study." This study is intended to assess the extent and severity of Post Traumatic Stress Disorder (PTSD) and other psychological problems among Vietnam theatre veterans, among other projected findings. When the analysis of "WAVE I" data is available from this study, Congress will have some more solid data on which to make decisions in regard to projected needs. As we understand it, the analysis of WAVE I should reach VA in August of this year, and be reported to the Congress by October 1, 1987. The final report, based on "WAVE II" and "WAVE III" results, is not likely to be completed until September 1, 1988.

However, perhaps the best measure of need is in the actual

number of veterans who seek services from the Veterans Outreach Centers. As you will note from the Table in Appendix I of this statement, the number of "New Clients" seen, the number of "Total Patient Visits," and the number of "Total Veterans Seen" has risen almost every year, as the Outreach Centers have become more effective in the communities where they are located. In Fiscal Year 1986, 141,700 veterans were provided needed services at the Outreach Centers, the most for any year to date of the program. Based on the figures of the first six months in FY 1987, over 75,000 new veteran clients will come to Outreach Centers seeking readjustment counseling assistance, and well over 150,000 total veterans will be provided vitally needed services. The fact that over 75,000 veterans who have never before sought assistance will come to the Outreach Centers during this year is proof positive of the continuing need. The old saying that "The proof is in the pudding" is certainly applicable here in that ever greater numbers of veterans are using the services provided by the Outreach Centers.

o CMD's Special Committee

The "Chief Medical Director's Special Committee on Post Traumatic Stress Disorder" was created pursuant to Public Law 98-528. In each of the first three years the Committee has done its work and submitted reports to the Administrator through the Chief Medical Director on time, in January of each of the respective years. The first report of this committee was due by statute to be delivered by the VA to the Congress not later than March 1, 1985. It was not delivered until over a year later. The

Second Annual Report was due to the Congress not later than March 1, 1986. It was not delivered until February of this year. The chronology is significant here because it is yet another instance of the systematic and cavalier disregard for Congressional intent when it comes to consideration of delivery of services to veterans for post traumatic stress disorder (PTSD) and other very real psychological wounds of combat. Such delay is in flagrant violation of both the letter of the law and Congressional intent, and is certainly deliberate, if not downright contemptuous, when it occurs three years in a row. VVA believes this is significant because it is consistent with the VA's current behavior in regard to premature closing of nine outreach centers. To do so is clearly in violation of the intent of Congress and this Committee (the true spirit of the law) even if it is not technically a clear violation of the letter of the law. Further, the unwarranted delay in forwarding the "CMD's Committee" reports on time is consistent with the delay experienced in implementing Public Law 99-166, which mandated creation of ten "Vietnam Veterans Resource Centers." It took seventeen months to move to fulfill the Congressional intent in regard to the "Super Outreach Centers." It took less than SEVENTEEN DAYS for the Administrator to approve destruction of nine Outreach Centers.

In the First and Second Reports, the Committee made it quite clear that they were extremely concerned with the lack of an adequate systemwide response on the part of the Veterans Administration to meet the needs of veterans in significant pain as a result of psychological wounds incurred as a direct result of

military service. As the Committee stated in the Preamble to their Second Annual report:

> The Special Committee is deeply concerned that legitimate requests for resource allocation will be dismissed because of current national preoccupation with reducing both the federal budget and the federal deficit. It was through no fault of their own that young men and women were asked to risk their lives in Vietnam. It was not their fault that national recognition of their valor and sacrifice was delayed until 1980. And it is not their fault that requests for long delayed treatment of their combat related PTSD should come at a time that the nation is reluctant to undertake any new expenditures.
>
> PTSD can be a devastating problem. If untreated it often gets worse with time. If there really is a national commitment to provide treatment for combat veterans with PTSD, then there must be a national willingness to provide that treatment.

More specifically, the CMD's Committee in the First and Second Annual Reports praised the work of the Outreach Centers by noting that the heavy PTSD case load of 88 Vietnam veterans per counselor was "remarkable," especially in light of the fact that the Outreach Center's target population are not limited to the treatment of PTSD. They noted that the Outreach Centers provide a "combination of services within a psycho-social context that includes war debriefing, individual therapy, crisis intervention, marriage and family counseling, special outreach to minorities, vocational counseling, social services networking and community liaison." In short, the CMD's Special Committee, most of whom are medical practitioners within VA Hospitals, state that the Outreach Centers are an extremely valuable part of the matrix of services that need to be offered to provide treatment for PTSD. This ringing endorsement of the Outreach Centers may be one reason why the Administration has tried to prevent the Congress from having

benefit of the counsel of this Committee.

As to the contents of the actual substance of the Third Annual Report, VVA, like the Congress, is without benefit of this Report because the Administrator refuses to obey the law and forward a report that has been written for over five months, and which was due to the Congress on March 1, 1987.

o Vet Center Planning Committee

The "Vet Center Planning Committee," an internal committee chaired by Thomas P. Mullon, Director of VAMC Minneapolis reported on January 6, 1986 the key points of their recommendation to include:

*"The present program should be continued after 1988, with no major alterations in structure, services or eligibility."

*"The Committee recommends that the Administrator should at this time forward a legislative initiative to Congress removing the concept of a general disbanding of the Veterans Outreach Centers during FY 1988."

*"With regard to need for services, on the part of Vietnam-era veterans, the utilization of services does not yet show any significant decrease." [Figures for the first six months of 1987 still do not show any decrease. In fact, the figures have increased. Please see Appendix I.]

*The organizational structure and its unique features have worked to emphasize recovery, orient combat veterans toward rehabilitation and, through early intensive and client-tailored services, have probably significantly decreased morbidity and need

for hospitalization."

In short, this Committee found that the need for services clearly continues to exist, and that the most effective and efficient way of meeting that need was to keep the current structure of the Veterans Outreach Center program, with outreach Centers located in and working with the local community. It is not only effective in human terms of reaching people before they reach an acute stage, it also saves significant dollars in the long term by reaching people at an earlier stage, before they require even greater amounts or intensity of treatment and/or disability compensation.

o GAO Report

On November 1, 1984 the Chairman of the Senate Committee on Veterans Affairs requested the General Accounting Office to examine specific aspects of the readjustment counseling program. This report has not yet been made public, which is unfortunate as VVA believes that the findings will buttress the already overwhelming evidence for the present continuation of community based VA Outreach Centers, at least until Congress has time to consider all of the results of the NVVRS.

Early indicators are that the GAO report will show no cost savings if Outreach Centers were closed and the RCS staff moved to VA Medical Centers. Further, indications are that willingness on the part of the veterans to seek needed services and treatment would be appreciably lessened if the Outreach Centers were destroyed and their staff absorbed into existing VA facilities,

and that the quality of and scope of care and services may be adversely affected by closing the Outreach Centers.

o Other Evaluations And Recommendations

The Veterans' Administration "Advisory Committee on Readjustment Problems of Vietnam Veterans" in the Winter of 1986 recommended to then Administrator Walters that the Outreach Centers be continued as is, with a gradual diminishment of sites based on utilization numbers. This recommendation essentially endorsed the Department of Medicine and Surgery's "Vet Center Planning Committee" recommendation. At the specific request of the new Administrator, General Thomas K. Turnage, in June of 1986, this Committee reexamined the issue of the Outreach Centers. After much deliberation, including meeting with the Administrator and DM&S officials, the Committee issued a much stronger recommendation, forwarded to the Administrator in early January of 1987, that all of the current number of the Community based Outreach Center delivery sites be maintained, but to relocate some to other community based sites as conditions warrant. No official reply has yet been received by the Advisory Committee, although it is obvious that their recommendations may not have been treated all that seriously.

The Veterans Outreach Centers have been examined by the Congress, by the press and by numerous internal mechanisms of the Veterans Administration. In every case the conclusion has been that the need for these services is a major one, and that the unique community based nature of the Veteran Outreach Centers is

the most efficient and cost effective way of reaching the veterans most in need of assistance.

COST

The Readjustment Counseling Service currently spends approximately $3 million per year for facilities to maintain the 188 community based Outreach Centers. It is estimated that the cost of moving the 9 Outreach Centers currently slated for elimination will be over $550,000, more than one sixth of the total space rental budget. To eliminate all of the Outreach Centers and relocate the remnants into the VA Medical Centers would cost at least $10 million, which is hardly a cost savings. Furthermore, to pretend that there is not a cost associated with space at the VA Medical Centers is simply naive.

Also significant in regard to the cost is that the Veterans Outreach Center Program, by policy and practice, does not encourage veterans to seek service connected disability compensation. Rather, the emphasis is on helping veterans get well, assimilate their war experience, and maintain their status within the fabric of family, job and community.

SEQUENCE OF EVENTS:

"A Tale of Two Pilots"

The Legally mandated Pilot

On December 3, 1985, Public Law 99-166 was approved. Section 105 of that law directed the Administrator to create the "Vietnam Veterans Resource Center Pilot Project" during the period

beginning January 1, 1986 to September 30, 1988. There were to be ten sites. These were the so-called "Super Veterans Outreach Centers" that could provide veteran benefit counseling, drug and alcohol counseling and other services. The program was to be evaluated and the Administrator was directed by law to report to this Committee with an assessment of the effectiveness of this program, conclusions, and recommended further activities in this regard.

Two sites were authorized by the Administrator on June 27, 1986--Anchorage, Alaska and New Orleans, Louisiana. On direct orders from VA Central Office, no formal opening was ever held for either VVRC pilot site. Anchorage began operation in November, 1986 and New Orleans became operational without public notice the following month.

VVA queried the Administrator and his staff numerous times during 1986 as to what was delaying implementation of the will of Congress regarding authorization for the other legally required eight sites. The Advisory Committee on Readjustment did likewise.

The Administrator, under the legal mandate of Congress via Public Law 99-166, was to furnish this Committee with the assessment report of experience in the ten sites by April 1, 1987. No such report has been forthcoming. Finally, after VVA strenuously queried a very senior VA staff member in late April, the Administrator authorized resources on May 11, 1987 as legally required to establish the other eight VVRCs called for in PL 99-166.

This flaunting of the clear intent of this Committee and the

will of Congress is, in the view of VVA, simply unacceptable. The letter of the law is clear. The intent to disregard both the letter and spirit of the law is equally clear in the extraordinary delay of seventeen months to even begin implementing this statute.

The Extra-Legal Pilot Program

Mr. Chairman, the VA has represented that the so-called pilot program of closing Outreach Centers is "not arbitrary," that it is a well conceived deliberate process, and really just a judicious management exercise. The chronology in the Appendix III of this statement should make it clear that this was in fact a pell mell rush to start destruction of Outreach Centers with a view toward total elimination of the community based sites. There was study and discussion of some type of a move within DM&S in the Fall of 1986. However, the process really began in earnest on January 12, 1987 when the "Chief of Staff", Col. James DeWire, demanded a list of targets by January 21, 1987. It is important to note that this decision to move toward destruction of sites occured before the Policy Advisory Board of the Department of Medicine and Surgery had considered the medical/professional wisdom of the move or the clinical merits of the criteria. It was also eight days before the Chief Medical Director had approved the concept of the move, or the clinical ramifications of same, or the appropriateness of the criteria to be used in selecting the targets. The Chief Medical Director finally (and by this time under tremendous pressure to do so) approved the "criteria" and the extra legal pilot program on January 20, 1987. The nine targets were finally

designated on January 23, 1987. The Administrator gave the order to move ahead on January 28, 1987. This process took less than seventeen days, in sharp contrast to the more than seventeen months it took to obey the law and move to implement the legally required and duly authorized pilot program for the VVRCs.

In the ensuing weeks, medical professionals and others cautioned the Administrator's staff that this process was proceeding too quickly and that mistakes may have been made in targeting. These entreaties and warnings were ignored.

Friday the 13th

On Friday, February 13th, 1987 Administrator Turnage was briefed in a large meeting by VA staff in preparation for budget testimony the following week. At that meeting the Chief Medical Director began to brief the Administrator on the Veterans Outreach Center program. The Administrator reportedly interrupted to exclaim "these need to be totally integrated [into the hospitals]." At this point the Administrator reportedly turned to General Counsel Donald Ivers and asked if present law barred moving the Outreach Centers into the VA Medical Centers. Mr. Ivers replied that his interpretation of the law was that there was nothing requiring the VA to maintain Outreach Centers in the community, only that the VA was authorized to do so. Administrator Turnage then asked Mr. Ivers if he could close all the community based Outreach Centers, and if he could begin to do so before the beginning of the legally mandated transition period. Mr. Ivers replied that in his opinion there was nothing in the law

to stop him.

This incident, together with the above cited instances of flagrant violation of Congressional intent and clear mandates of the letter of the law, argue strongly for immediate passage of HR 2146 and rigorous oversight to ensure that both the letter and the spirit of the law are carried out. In all of the deliberations of this Committee since the inception of the Veterans Outreach Centers in 1979, the intent of the Committee has been clear that these services are to be provided in the unique community based delivery facility. This Committee has relied on the long standing gentleman's agreement that the Administrator, his General Counsel, and the Title 38 mandated staff would seek, as a matter of decency and trust necessary to our democratic system, to fulfill the intent of Congress. It seems that this is no longer a valid assumption in this case. Passage of HR 2146 will mandate in the letter of the law what has always been the intent of this law: that Readjustment Counseling Services be delivered in community based Veterans Outreach Centers separate and apart from the VA Medical Centers unless Congress mandates otherwise.

Unfortunately, in light of the flaunting of the letter of the law of Public Law 99-166, passage of HR 2146 may have to be only the first step. Indications in this case are that rigorous oversight and vigilance of the committee will be necessary to prevent the political structure within VA from subverting the clinical aims of the Veterans Outreach Center in delivering quality medical care to those who have suffered the very real psychological wounds of war.

SUMMARY

Mr. Chairman, Vietnam Veterans of America urges the promptest possible passage of HR 2146. This legislation simply reiterates decisions made by previous sessions of Congress that the "transition period" of closing community based Outreach Centers and relocating the Readjustment Counseling Program into VAMCs not begin until Congress has had the opportunity to review the findings of the National Vietnam Veterans Readjustment Study."

We wish to impress upon this Committee the urgency of this legislation, as the Administrator of the VA has already begun this process in flagrant violation of the will of Congress. In fact, the Wilmington, Delaware Outreach Center has already closed as of May 1 of this year. As you will note from the chronology in Appendix III, the VA has embarked on what will be an inexorable process, unless Congress intervenes by means of speedy passage of HR 2146.

Vietnam Veterans of America thanks you Mr. Chairman for the opportunity to present our views on this issue of vital importance to Vietnam veterans. As always, VVA is admiring and appreciative of your leadership on this and other issues.

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VVA Appendix I
May 20, 1987

OUTREACH CENTER UTILIZATION

FISCAL YEAR	NEW CLIENTS	TOTAL PATIENT VISITS	TOTAL VETERANS SEEN
1980	28,700	78,800	28,900
1981	45,600	206,400	60,300
1982	51,000	292,900	82,900
1983	69,600	392,100	103,200
1984	75,600	417,400	114,400
1985	65,200	390,100	107,000 (Estimate)
1986	71,000	517,250	141,700
1987*	75,200	562,750	152,115

* Projected on the basis of the first six months of reports for FY 1987 by the new Program Activity Reporting System 9(PARS) of the Readjustment Counseling Service.

• A not-for-profit national veterans' organization •

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VVA Appendix II
May 20, 1987

Chronology of Legally Mandated "Vietnam Veteran Resource Center Pilot Project (VVRC)" (Pursuant to PL 99-166)

Dec. 3, 1985	Public Law 99-166 approved
Late Dec., 1985	Announcement of departure of Veterans Administrator Harry N. Walters
Jan. 1, 1986	VVRC mandated to begin. No action taken.
Jan. 31, 1986	Administrator Walters leaves VA
Feb., 1986	Thomas K. Turnage nominated for Veterans Administrator
March, 1986	Administrator Turnage confirmed by Senate.
April-May, 1986	Still no action on VVRC pilot.
June 27, 1986	Two of mandated ten sites approved for Anchorage, Alaska and New Orleans, Louisiana. Projected 90 day period to become operational.
July-Sept., 1986	No action on remaining 8 sites.
Nov. 28, 1986	Anchorage VVRC becomes operational with no public ceremony as per orders from VACO.
Dec. 12, 1986	New Orleans VVRC becomes operational with no public ceremony as per orders from VACO.
Jan.-March, 1987	No action taken on remaining 8 sites.
April 1, 1987	Administrator's Report due to Congress on assessment of first 15 months of pilot program. No report filed.
April, 1987	VVA questions blatant defiance of PL 99-166.
May 11, 1987	Administrator approves the remaining 8 sites mandated by law seventeen months late. (Chicago; Houston; San Juan; South-Central Los Angeles; McKeesport, PA; St. Paul, MN; Birmingham, AL; Brooklyn, NY). Projected 90 day period to become operational.

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VVA Appendix III
May 20, 1987

Chronology of Extra-Legal
Pilot Program to Close Community Based
Veteran Outreach Centers

Early Fall, 1986	Department of Medicine and Surgery (DM&S) begin discussion of possible "pilot project" to relocate a small number of Outreach Centers as a component of long range deliberate planning.
Late Oct., 1986	Readjustment Counseling Service (RCS) prepares tentative criteria for selecting sites feasible for moving.
Nov., 1986	RCS field officials review proposed criteria for site selection and furnish a tentative list of possible sites.
Nov.-Dec., 1986	Draft criteria apparently furnished to DM&S.
Jan. 5, 1987	Administrator receives new recommedation from Advisory Committee on Readjustment to retain all community based sites.
Jan. 12, 1987	Col. DeWire orders list of targets be prepared and on his desk by Jan. 21, 1987
Jan. 13, 1987	DM&S Policy Advisory Board recommends approval of criteria; forwarded to Chief Medical Director (CMD) for aciton.
Jan. 15, 1987	As ordered, DM&S holds special meetings to compile list of targets.
Jan. 20, 1987	CMD approves criteria.
Jan. 23, 1987	Final list of nine targets rendered unto Col. DeWire.
Jan. 27, 1987	Executive Assistant Joan Lamb and "Chief of Staff" Col. DeWire recommend final approval of targets.
Jan. 28, 1987	VA Administrator, General Thomas Turnage, gives order to proceed on targets without delay.

Jan. 28, 1987	CMD notified to proceed on targets.
Jan. 28, 1987	RCS notified to proceed on targets.
Jan. 29, 1987	RCS notifies regions to proceed on targets.
Friday, Feb. 13, 1987	General Turnage states intention to close all community based Outreach Centers. General Counsel Donald Ivers advises that in his opinion there is nothing to stop the Administrator from closing ALL of the community based Outreach Centers, and nothing to stop him from beginning to do so before mandated transition period.
*March 28, 1987	Landlord notified of cancellation of lease in Rochester, NY.
*April 15, 1987	Landlord notified of cancellation of lease in Northbridge, CA; Fayetteville, NC; Wilmington, DE.
*May 1, 1987	Wilmington Community Based Outreach Center closed.
*May 29, 1987	Landlord to be notified of cancellation of lease in Oak Park, IL.
*June 1, 1987	Landlord to be notified of cancellation of lease in Houston, TX.
*June 15, 1987	Landlord to be notified of cancellation of lease in Milwaukee, WI.
*June 22, 1987	Rochester Community Based Outreach Center to close.
*July 1, 1987	Landlord to be notified of cancellation of lease in Sioux Falls, SD.
*July 1, 1987	Fayetteville Community Based Outreach Center to close.
*July 3, 1987	Northbridge Community Based Outreach Center to close.
*July 16, 1987	Houston Community Based Outreach Center to close.
*Sept. 9, 1987	Avon, Mass Community Based Outreach Center to close.

*Sept. 10, 1987	Oak Park Community Based Outreach Center to close.
*Sept. 30, 1987	Milwaukee Community Based Outreach Center to close.
*Sept. 30, 1987	Sioux Falls Community Based Outreach Center to close.
Oct. 1, 1987	Legally mandated transition period to BEGIN under present law (5/20/87).

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*These dates may be approximate as they were reported to VVA by our members and chapters from many different sources.

Statement of

The American Legion

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WASHINGTON, D. C. 20006

by

PAUL S. EGAN, DEPUTY DIRECTOR
NATIONAL LEGISLATIVE COMMISSION
THE AMERICAN LEGION

and

RODNEY S. KIRK, ASSISTANT DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION

before the

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

on

VARIOUS HEALTH CARE LEGISLATION

May 20, 1987

STATEMENT OF RODNEY S. KIRK, ASSISTANT DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
MAY 20, 1987

Mr. Chairman and Members of the Subcommittee:

The American Legion appreciates this opportunity to present its views on the several proposals relating to veterans health care that are under consideration today.

H.R. 2001 would extend the Adult Day Health Care Program and authorize contract halfway house care for veterans with chronic psychiatric disabilities.

The American Legion supports the section of this bill which would amend title 38, USC, to extend the Adult Day Health Care Program.

In November 1983, through enactment of PL 98-160 this program was authorized through September 1988. In reality, this program did not get started until 1985, at which time The American Legion was informed there was not any research money available to accommodate section 103 of PL 98-160 which mandated a study to measure the cost-effectiveness and medical efficacy of furnishing such care as an alternative for nursing home care. In addition, this study, which was to be submitted to the Committees on Veterans Affairs of the Senate and House of Representatives, no later than February 1988, was to compare the advantages and disadvantages of VA's own program as compared to contracting with non-VA facilities in the community for these services.

The American Legion has been informed by VACO officials that VA is now ready to begin such research at 4 sites located in Miami, Minnesota, Little Rock, and Portland. At least one full year of data collection will be required before any valid conclusions can be reached.

Mr. Chairman, by the end of Calendar Year 1987, there will be in operation, 15 VA operated Day Care Centers. Currently, only 9 are operational, either on a VAMC campus or within rented space in the community. The current average daily census is 325 veterans. In addition, VA has just recently granted authorization to 15 VA medical centers to contract for day care.

The American Legion has consistently supported the theory of maintaining the veteran-patient in the community as much as, and for as long as possible. These Adult Day Health Care Programs, oftentimes a direct alternative to nursing home care, provide a one-stop service to veteran-patients for nursing needs, nutrition services, social services, rehabilitation requirements, medical management, and socialization. The American Legion has stated on a number of occasions during hearings before this Subcommittee that it is our intent to encourage both Congress and VA to foster the development and implementation of all the innovative techniques that can be used to both make the system more cost-effective, and able to care for the largest number of patients. The Adult Day Health Care Program is such a technique, and we strongly support the extension proposed in this bill.

Also included within this bill is a section to authorize contract halfway house care to veterans with chronic psychiatric disabilities.

This proposal would authorize VA to establish a pilot program to provide contract treatment in halfway houses, therapeutic communities, psychiatric residential centers, and other community-based treatment facilities to eligible veterans with chronic psychiatric disabilities.

Currently, VA has only a few alternatives for placement of veterans with chronic psychiatric disabilities after discharge. At times, the veteran-patient in this category can be placed in community nursing homes, but this alternative is rarely used because community nursing homes oftentimes refuse these types of patients, or simply admit them until problems arise and then send them back to VA. Most often, this type of patient is placed on outpatient status, wherein the level of care and supervision is not adequate, oftentimes resulting in the revolving door syndrome.

The American Legion supports the theory of maintaining the veteran-patient in the community to obviate the need for hospitalization. However, we would caution that these alternatives may provide some VAMCs with the "authority" to prematurely discharge patients before their inpatient therapeutic treatment is totally complete. This action may be a response to potential negative DRG reimbursement within a specific facility.

H.R. 2002 is a bill to amend title 38, USC, to authorize the Administrator of Veterans Affairs to provide "on call" pay to certain civil service health care personnel.

The bill would amend section 4107 of title 38, USC, by adding a new section (j) authorizing the Administrator to provide "on call" pay to civil service health care employees appointed pursuant to title 5, USC or section 4104(3) of title 38, USC, in the same manner that this pay is provided to title 38 registered nurses, under section 4107(e)(8).

The American Legion recognizes the intent of this proposed bill is to provide the Administrator authority to require these civil service health care personnel to remain available for "on call" duty as necessary, and to pay them "on call" pay instead of standby premium pay. The American Legion does not object to this proposal.

H.R. 2003 is a bill to amend title 38, USC, to authorize the Chief Medical Director to waive State licensure requirements for registered, practical or vocational nurses and physical therapists not to be employed in patient care, and for licensed or vocational nurses and physical therapists to be employed in a foreign country.

The Chief Medical Director currently has the authority to make such waivers in cases of physicians, dentists, psychologists, podiatrists, and optometrists, and we have no objection to the inclusion of these other personnel for the purposes set forth in 38 USC 4114(d). The American Legion would stress however, that strict controls must be maintained on such individuals to ensure that their limited appointment is not forgotten, and that they do not eventually assume patient responsibilities.

H.R. 2004 is a proposal that would clarify and expand the authority of the Chief Medical Director (under 38 USC, 4106(b)). That section establishes the probationary period for certain employees in DM&S, and requires periodic review of the employees' performance. The employees affected are physicians, dentists, podiatrists, optometrists, nurses, physician assistants, and expanded function dental auxiliaries.

This proposal would clarify the Chief Medical Director's authority to accept, reject or modify the findings and recommendations of Professional Standards Boards, therein making the Chief Medical Director or his designee, the decision-maker rather than the Professional Standards Board. This proposal would not limit an employees' rights.

In addition, the provision would authorize corrective action other than removal when an employee, upon review, is found not fully qualified and satisfactory. Currently, the law states that the individual, upon such a finding, is to be removed. This proposal would provide discretionary power to the Board and the Chief Medical Director to seek alternative actions against such an employee, as opposed to termination of employment. The American

Legion has no position on this legislation, basically because it entirely involves internal personnel matters relating to the Veterans Administration.

H.R. 2006 would amend section 603(a) of the title to provide the Veterans Administration with the authority to pay for emergency hospital care for veterans who have been placed in community nursing homes at VA expense.

The American Legion is supportive of this provision.

The second proposal contained in this bill would amend section 620 by authorizing the Veterans Administration a maximum per diem rate for contract nursing care of 50 percent of the cost of care in a community general hospital in Alaska and Hawaii, as opposed to the current limitation of 45 to 50 percent of the cost of care in a VA general hospital. This should provide VA with greater ability to obtain needed care for veterans in those two States, and we would support it.

The third provision set forth in H.R. 2006 would amend section 624(b) of the title to provide service-connected veterans who are foreign nationals residing abroad with eligibility for VA health care for their service-incurred disabilities. As the letter of transmittal states, this change would primarily benefit a group of Canadian citizens who were disabled while serving with U.S. forces in Vietnam. The American Legion urges the enactment of this proposal.

This measure would also clarify VA's authority to provide medical services to veterans participating in a vocational rehabilitation program outside the U.S., and we support that intent.

H.R. 2007 is a bill designed primarily to clarify existing legal authority. One proposal would amend the statutory definition of the term "nursing home care" to include both skilled and intermediate levels of care. The American Legion does not object to this proposal based on the fact that VA has always provided these levels of care in their nursing homes.

This proposal would also clarify VA's authority to provide veteran-patients with therapeutic recreational activities outside the confines of a VA facility. Enactment of this bill would establish specific legal authority for such activities, and The American Legion has no objection to this proposal.

Included within H.R. 2007, is a proposal that would make persons disabled by VA treatment, examination, or vocational rehabilitation eligible for outpatient care for the disability for which compensation is being awarded under section 351, title 38, USC. Such persons are currently eligible for VA hospital and nursing home care as if service-connected, but are eligible for limited outpatient care, primarily to obviate the need for hospitalization or to complete hospital care.

The American Legion supports this proposal to provide eligibility to persons disabled by VA treatment, examination, or vocational rehabilitation for outpatient care to the same degree as service-connected veterans.

H.R. 2010 would authorize modification of the structure of the Office of the Chief Medical Director and provides authority for other administrative procedures.

These are all administrative changes to which The American Legion has no objections.

H.R. 2146 would amend 612A of the title to extend the transition period during which time the provision of readjustment counseling services were to be shifted from storefront operations to existing VA facility grounds.

Currently, section 612A(g)(1) states this transition is to be accomplished during the period of October 1, 1987 to September 30, 1989 (PL 99-272). The transition is to be orderly and gradual. H.R. 2146 would extend the date for completion of this transition to September 30, 1990. The American Legion has no objection to this provision, which we are mandated to support through Resolution No. 548, approved by Delegates to our 1986 National Convention.

Section 612(g)(2) now requires the Administrator to report to Congress on the effectiveness of the VA's readjustment efforts for Vietnam Era veterans no later than April 1, 1987. H.R. 2146 would extend the deadline for this report to April 1988.

H.R. 2146 would also extend for one year, to July 1, 1988, another report by the Administrator, containing a description of the plans made and timetable for the Vet Center transition.

Subsection (g)(4) requires a report by February 1, 1989, on VA's experience on as much of the transition as had been accomplished by December 30, 1988. H.R. 2146 would extend the due date of the report to February 1, 1990, covering the period up to September 30, 1989. Included within this report will be the Administrator's opinion as to the extent to which the current Vet Center Program is needed.

H.R. 2146 would also add a provision to maintain in operation the same number of Vet Centers as existed on April 1, 1987, until October 1, 1988.

Finally, reference is made to extending the deadline for the report due under PL 98-160 on the VA's study of PTSD and other post-war psychological problems of Vietnam veterans, including VA's treatment of such veterans and providing benefits, from October 1, 1986 to October 1, 1987. The American Legion supports each of the foregoing provisions.

H.R. 2327 provides specific statutory authority versus the current discretionary authority, for reimbursement of beneficiary travel expense for:

a. A veteran traveling in connection with treatment of a service-connected disability;

b. A veteran rated 50 percent or more for a service-connected disability;

c. A veteran receiving nonservice-connected pension or eligible to receive nonservice-connected pension;

d. A veteran whose annual income does not exceed the maximum annual rate of pension, if they were eligible for pension;

e. Ambulance travel where medically indicated and it is determined the veteran is unable to bear the cost; and

f. A veteran who is determined to be unable to defray the cost of travel.

The purpose of such payments remains the same as specified in 38 CFR 17.100 - 17.102. The American Legion supports this measure which would make the Beneficiary Travel Program an entitlement.

The last proposal we will address is a Discussion Draft titled: "Veterans Administration Health Care Amendments of 1987."

Section 2 of this Act would amend 612(a)(1) to state that the Administrator shall furnish medical services to any veteran entitled to hospital care under section 610(a)(1) of title 38.

The American Legion would support this proposal as it would strengthen the provision of these benefits to eligible veterans.

Section 3 would amend section 610(b) of title 38 with respect to eligibility for domiciliary care. The American Legion has no objection to this section which merely clarifies the language that sets forth the eligibility criteria for domiciliary admissions.

Sections 4 and 5 contain proposed increases in pay scales for DM&S personnel. These are administrative proposals to which we have no objection.

Section 6 of this proposal relates to the appointment and authority of disciplinary boards for medical personnel.

The issues proposed in this section are administrative issues and The American Legion does not object to them.

The American Legion has no objection to Section 7, which amends 4142(a)(1) to include categories of health care and scientific personnel who would be eligible to participate in the scholarship program. Several categories of needed medical skills are included within this provision which will enhance the scholarship program and VA's cadre of personnel, thus we support the proposal.

Section 8 adds new section 5010(a)(6)(A) to exclude temporary research personnel from VA FTEE or other ceiling limits. Definition of temporary research personnel means non-career appointment for work on research activities by individuals not paid by VA. The American Legion has no objection to this provision.

Section 9 proposes a pilot program on hospital management efficiency. The purpose is to determine the effect of additional authority on the efficiency and economy of the management of 5 VAMCs. Under the program, the Director of a designated VAMC may waive or alter such laws and regulations applicable to the management of the facility to improve efficiency and economy. Budget support would be maintained for the period, regardless of any improved efficiency or economy of operation. A report shall be submitted to Congress annually. The program would expire on September 30, 1990.

The American Legion foresees the potential in such a pilot program and if enacted will review with interest the annual reports submitted to Congress by the Administrator, as required by this section.

Section 10 of this proposal would authorize VA to establish a pilot program to provide contract treatment in halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities to eligible homeless veterans suffering from chronic mental illness disabilities.

The American Legion supports this provision for reasons outlined earlier in this statement under H.R. 2001.

Mr. Chairman, that completes our statement.

STATEMENT OF
JOHN A. GRONVALL
CHIEF MEDICAL DIRECTOR
BEFORE THE
SUBCOMMITTEE ON HOSPITALS
AND HEALTH CARE
HOUSE VETERANS' AFFAIRS COMMITTEE
MAY 20, 1987

Mr. Chairman and Members of the Subcommittee:

I am pleased to appear before you today to testify on the many important measures on your legislative agenda. The objectives inherent in these proposals--to improve VA health care and health-care administration and to assure that VA has the tools to recruit and retain needed health-care personnel--are objectives we share. We are pleased to have the opportunity to offer our perspectives on these vital subjects. We also appreciate your introducing so many of the legislative proposals we have submitted and your inclusion of these bills for consideration at this important hearing.

MANDATORY ELIGIBILITY--OUTPATIENT CARE

Among the most far reaching of the proposals before the Committee is section 2 of the bill which would amend section 612 of title 38 first to expand the number of categories of veterans eligible for comprehensive outpatient care, and second, to mandate that VA provide outpatient care to those veterans. For the reasons discussed below we object to the enactment of section 2.

Current law provides that the Administrator may furnish needed outpatient care to any veteran for a service-connected disability, and to service-connected veterans rated at least 50 percent disabled for any disability. Essentially comprehensive outpatient care may also be furnished to veterans of World War I or earlier wars, to certain profoundly disabled VA pensioners, and to former prisoners of war. Other veterans are eligible for outpatient care only if it is needed to prepare them for hospital care, to obviate the need for hospital care, or if the care is required as a followup to a period of inpatient care. Current law generally limits such followup outpatient care to a twelve-month period.

Section 2 of the bill would expand eligiblity for essentially comprehensive outpatient care to all veterans for whom VA has an obligation to furnish hospital care, the so-called "category A" veterans.

Major additional categories of veterans who would be made eligible for open-ended outpatient care for any disability would be all service-connected veterans regardless of their disability rating, and all lower income nonservice-connected veterans, those with annual incomes below $15,195 if single. In our view, existing outpatient care eligibility is consistent with the VA's principal mission. Congress has long required VA in providing ambulatory care to give highest priority to care of veterans' service-connected conditions, and second priority to the very severely disabled service-connected veterans (those rated at least 50%). Congress has also assigned priorities (in section 612(i) of title 38, U.S. Code) to the treatment of other service-connected veterans, former prisoners of war, and certain other veterans. To the extent that VA can meet the needs of those veterans assigned a statutory priority, VA also provides outpatient care to many other veterans, consistent with current law.

This bill would fundamentally alter the VA's role, however, directing that outpatient care be provided to the entire spectrum of lower income veterans whose disabilities have no relationship to their service, and without regard to the severity of their medical needs. Furthermore, a major revision of eligibility for VA medical care has only recently occurred (P.L. 99-272). Implementation of this revision was initiated on July 1, 1986. Full assessment of the impact of this revision is therefore not yet possible. An assessment of probable cost and the extent to which outpatient care provided is actually meeting the needs of [illegible] veterans should be made prior to further legislative revision of eligibility.

We therefore recommend that the proposed legislation not be enacted.

DOMICILIARY CARE

Section 3 of the draft bill would amend the eligibility provisions for VA domiciliary care. It would establish a veteran's inability to defray the expenses of needed domiciliary care as a single criterion of eligibility. We support this provision.

Under existing domiciliary care eligibility provisions, the law appears to impose more stringent requirements on the service-connected veteran than on other veterans. Thus, to be eligible for domiciliary care, the service-connected veteran must have a permanent disability, tuberculosis, or a neuropsychiatric ailment; be incapacitated from earning a living; and have no adequate means of support. In contrast, statutory provisions governing domiciliary eligibility for other veterans impose none of these requirements, and condition eligibility on an "inability to defray" and a need for such care. Under existing regulations, however, eligibility for domiciliary care generally requires that a veteran be incapacitated from earning a living and have no adequate means of support. The requirement that a veteran have no adequate means of support as a condition of eligibility for domiciliary care is considered to mean in general that the applicant has an income of less than $415 per month. We would anticipate that if this provision is enacted implementing regulations would continue in effect such income limits.

PAY SCALES FOR DEPARTMENT OF MEDICINE AND SURGERY

Section 4 of the draft bill would revise the pay schedules in section 4107 of title 38 for senior Central Office DM&S employees appointed under section 4103 of title 38 and for physicians, dentists, nurses, clinical podiatrists, and optometrists appointed under section 4104(1). These revisions would update these pay schedules to conform with the current pay rates increased by Executive Order 12578 of December 31, 1986. We favor this provision.

We would recommend that the ceiling on the base pay for the position of Associate Deputy Chief Medical Director (ADCMD) be raised from Executive Level V to Executive Level IV, making it equal to the ceiling on pay of the Deputy Chief Medical Director. While it is unusual to place the salary of a subordinate on a par with that of the individual's supervisor, this change merely reflects the unique managerial roles expected of ADCMDs, who are charged with the responsibility of administering a vast and complex medical care system. The rate increase is in recognition of the singular leadership qualities and resourcefulness demanded of an ADCMD.

The changes in the pay schedules recommended by your bill, and raising the ADCMD grade level, are contained in the VA's own legislative proposal to reorganize the Office of the Chief Medical Director. We appreciate, Mr. Chairman, your introducing our proposal as H.R. 2010. We will discuss the other major features of H.R. 2010 toward the end of this statement, along with our other legislative proposals.

SATURDAY PREMIUM PAY FOR REGISTERED NURSES

Section 5(a) of the draft bill would require VA to provide premium pay to registered nurses for Saturday duty. Currently, section 4107(e)(3) of title 38 requires VA to pay a registered nurse additional pay up to 25 percent of the nurse's hourly rate of basic pay for duty on Sunday.

VA has authority to provide premium pay to nurses for Saturday duty under section 4107(e)(10) and is now exercising this authority based on need. We believe that this existing authority is not only more flexible than proposed by the bill, but it can be directed specifically to meeting the main purpose of premium pay--to recruit and retain nurses for VA. A Department Task Force charged with studying recruitment and retention problems has identified expanded-use of this premium-pay authority as one element of part of a possible long-term solution to these problems.

Therefore, we oppose this provision not only because VA already has a more flexible premium-pay authority, but also because of the associated high costs of mandating such premium pay throughout the Department. Presuming that the Saturday premium pay would be equal to that paid for Sunday premium pay, we estimate that the cost of this provision to be $21 million for Fiscal Year 1989 and a five-year cost estimate of $115 million.

APPOINTMENT OF PHARMACISTS UNDER TITLE 38

Section 5(b) of the draft bill would allow VA to hire and pay registered pharmacists under the title 38 personnel system, while other employment matters concerning pharmacists, such as performance appraisal, leave, hours of duty, adverse action, and probationary periods, would continue to be governed under the provisions of title 5.

The main objective of this provision is to assist VA in recruiting and retaining pharmacists. However, because we do not believe that this provision will significantly achieve this objective, we do not favor its enactment. This provision is similar to provisions of Public Law 98-160, which authorized appointment and pay under title 38 of respiratory therapists, physical therapists, and licensed practical/vocational nurses. At the time this legislation was passed, the Administration expressed concern that the special personnel authorities were unnecessary and costly and singled out VA for special treatment. It is our experience that the change in appointment authority of these professions did not significantly enhance recruitment and retention, except with respect to respiratory therapists.

The only practical advantage we find to this provision is granting VA authority to approve special rates for pharmacists without the requirement for review by the Office of Personnel Management before the rates become effective. Based on our experience with Public Law 98-160, we estimate that this provision would result in a six- to eight-week reduction in the time required to process special rate requests. We do not see how this advantage is sufficient to justify this provision.

DISCIPLINARY BOARDS FOR MEDICAL PERSONNEL

Section 6 of the draft bill would limit the appointment of disciplinary boards for employees appointed under section 4104(1) of title 38. Under this provision, VA could simplify disciplinary procedures affecting these employees in cases where the proposed penalties are relatively light. VA supports the proposal, but would favor augmenting the bill to include authority for delegating both the power to appoint disciplinary boards and to act on disciplinary board recommendations as contained in our bill, H.R. 2009, which you have introduced at our request.

Currently section 4110 of title 38 mandates a rather cumbersome peer review process for disciplinary actions against non-probationary physicians, dentists, podiatrists, optometrists, nurses, physician assistants and expanded-function dental auxiliaries, for reasons of inaptitude, inefficiency, or misconduct. There is no distinction based on seriousness of offenses. Current procedures involve notice of charges, opportunity for a pre-decision hearing, right to legal representation and post-decision appeal for the least serious cases, such as a three-day suspension for a minor offense, such as well as for the most serious offense, such as removal for patient abuse. The hearing, required at the request of the employee, is a trial-type adversarial hearing of which a verbatim transcript is taken.

The current disciplinary board system has proven to be overly centralized, time-consuming and highly legalistic, with an average case taking between nine and fourteen months to complete. As the volume of disciplinary actions increases, further processing delays are incurred. The effect of the complexity of the current disciplinary board system has been to diminish the use and usefulness of disciplinary actions as a behavior-modifying measure to maintain high standards of patient care in the medical centers. Because the current system uses such large amounts of time and resources, it discourages managers from proposing moderate penalties and thus tends to frustrate the progressive discipline approach.

The draft bill would limit the use of the disciplinary board machinery to cases where the proposed penalties are most serious: removal, suspension of more than 14 days, or demotions involving loss of grade or basic pay. All lesser disciplinary actions would be excluded. Administrative appeal or grievance procedures would be established for these latter actions under regulations prescribed by the Administrator pursuant to current authority. As a result, the volume of section 4110 disciplinary actions would be reduced. Further, lesser disciplinary actions would be less costly and cumbersome and therefore more readily invoked so that progressive discipline would be more feasible.

We strongly believe any change to the disciplinary board process should clearly enable those cases that remain covered by section 4110 to be more expeditiously resolved, by giving VA the express power to delegate authority to appoint boards and act on board recommendations. The current bill, while providing for regulations to govern appointing boards, also repeals the current explicit authority to delegate both board appointments and review of board recommendations. Thus, the bill would require the involvement of the Administrator in the appointment and review process of each and every boardcase. Therefore, it would not go far enough to solve the problems in the current system.

On the other hand, the VA bill, H.R. 2009, would change the current system by expressly authorizing the Chief Medical Director to delegate the current board-appointing authority and by expressly empowering the Chief Medical Director to redelegate the authority currently delegated to him by the Administrator to act upon recommendations of the board. In addition, the current bill would appear to reach conduct only in connection with duty. It should be amended to authorize boards to hear issues involving off duty misconduct as well.

Decentralizing the disciplinary board process would expedite board results and thus better serve the affected employee's interest in getting a timely result.

We believe this provision would result in some limited cost savings through reduced expenses for processing disciplinary actions although the major benefits would be a more responsive and timely disciplinary system.

COURSES OF TRAINING FOR HEALTH PROFESSIONS SCHOLARSHIP PROGRAM

Section 7 of the draft bill would provide VA with more flexibility to grant scholarships under the VA Health Professionals Scholarship Program by extending eligibility for these scholarships to all employees covered under section 4104 of title 38.

Currently, eligibility for these scholarships is limited to individuals accepted for enrollment, or enrolled, as a student in a course of training leading to a degree in medicine, osteopathy, dentistry, podiatry, optometry, or nursing, or to become a physician assistant or expanded-function dental auxiliary. Section 7 would extend eligibility to include those seeking degrees for other health-care professions, such as pharmacists, psychologists, dieticians, occupational and licensed physical therapists, and licensed practical or vocational nurses.

The scholarship program has proven to be a highly successful method for recruiting and retaining health care professionals for VA. Participants receiving these scholarships are obligated to work for VA upon completion of their training. The majority of those participants who finish their period of obligation remain with VA afterwards.

The current program does not provide VA the flexibility to grant scholarships to meet recruitment needs as shortages develop in other health-care professions, such as physical therapists, for which there currently is a shortage in VA.

We therefore favor the Committee's proposal, which would assist VA in diminishing the adverse effects of future shortages for those health-care occupations we employ under title 38. If enacted, VA would expend an additional $1 million in fiscal year 1988 for scholarships for physical therapists, which is already contemplated in the President's 1988 budget.

We would also recommend that section 4144 of title 38 provide that individuals in the professions being made eligible for the Scholarship Program under this bill be also liable for the same penalties as are now prescribed for those currently eligible for the Program.

PERSONNEL CEILINGS - RESEARCH

Section 8 of the bill would exclude temporary research personnel employed by the VA for any personnel ceiling on full-time equivalent employees, or from any other personnel ceiling applicable to VA employees. Temporary research personnel are defined in the section as non-career VA employees working on a

research activity, and who are paid with funds appropriated for research, or with non-VA funds, such as a grant from a private entity to fund a joint VA/private research project.

This provision would address an issue VA has faced in our research program. In our view, however, it has become apparent that the issue does not require a legislative solution. Rather, in those instances where research initiatives would be frustrated because of a personnel ceiling, the ceiling can be adjusted administratively on a case by cases basis.

We are looking further into the program and hope to see what experience other agencies have had in dealing with it.

PILOT PROGRAM--HOSPITAL MANAGEMENT EFFICIENCY

Section 9 of the draft bill would provide VA authority to conduct a pilot program under which we could explore the feasibility of operating VA medical centers free of certain statutory and regulatory constraints which the Administrator determines are appropriate for waiver. We believe such a pilot effort could lead to improvements in the efficiency and effectiveness of our medical centers, and we favor the enactment of such authority.

Specifically, the measure would call for VA to designate five medical centers at which each center's director, pursuant to the Administrator's authorization, could waive or alter any laws and regulations applicable to the center's management and administration to determine the effect of such waivers or alterations on the efficiency and economy of the center. This pilot effort at achieving management efficiency would be authorized to operate through September 30, 1990.

We view this concept as offering an important opportunity to explore mechanisms for increasing the timeliness and cost efficiency of our service delivery systems, and we welcome it. We anticipate that by selectively removing constraints in such areas as fiscal, personnel, and procurement administration, we can evaluate whether this will enable our managers to achieve efficiencies and economies without diminishing the integrity of our operations.

While we support adoption of this proposal, we do however recommend a number of changes. Thus, instead of providing, for example, that the medical center director may waive laws and regulations (pursuant to the Administrator's authorization), we believe that the Administrator, with the concurrence of the Agency whose laws are being effected, should be the exclusive official vested with such authority, and that the bill should permit him to authorize the directors of the "test" facilities to operate their respective facilities without regard to those laws and regulations which he has waived. In addition, we would suggest that you clarify the meaning of the provision authorizing not simply the waiver of a law's application but also authorizing officials to "alter such laws." We are uncertain as to the scope of that authority. For example, one could construe that phrase, as drafted, as authorizing the directors, notwithstanding limitations in law on the availability of medical care monies, to retain until September 30, 1990, such monies as might be allocated. While such authority would be desirable within the framework of the pilot program, it is not clear whether such an "alteration" of law is contemplated.

As a final point, we note that the draft bill would vest the Administrator with very broad authority to waive virtually any law relating to the operations of a medical center. We would not contemplate sweeping waivers of statutes. Thus, we do not intend to waive fundamental civil service and procurement laws, for example, or to alter basic patient care eligibility and priority of care provisions. Additionally, subject to a few limited exceptions, our "test" medical centers would also remain subject to established principles of appropriations law. With enactment of the draft bill, we would anticipate that, through the exercise of limited waivers, the pilot program would include the following:

--Lifting of specific funding constraints on when, and for what, the test facilities may obligate the allotted funds which they receive from the Medical Care appropriations.

--Authorization for the test facilities to carry over to the next fiscal year unobligated portions of their annual

allotments from the Medical Care appropriation for the duration of the pilot program.

--Lifting of employee travel funding restrictions, and

--Suspending mandatory participation of test facilities in A-76 studies, and waiver of section 5010(c) of title 38, U.S. Code regarding so-called "contracting out."

In general, lifting what, for test purposes, may be considered restrictive constraints in such areas as fiscal, personnel, and procurement administration, should enable our managers to achieve substantial efficiencies and provide better service.

HOMELESS VETERANS

Public Law 100-6 provided, in pertinent part, for the transfer to the Veterans Administration medical care account of some $5 million out of funds previously appropriated for Fiscal Year 1987, to be available to carry out the new contract authority granted the Administrator in that law (codified at section 620C of title 38, U.S. Code). VA is currently developing contract arrangements under that authority to furnish community-based residential treatment to chronically mentally ill homeless veterans. Public Law 100-6 set a $5 million spending limit on the use of this new authority. Section 10 of the bill would repeal section 620C and authorize a one-year pilot program to provide community-based residential care to homeless chronically mentally ill veterans. This measure would authorize appropriations of $6 million in FY 88 for the program. The bill would limit funding for the program to monies specifically appropriated for that purpose and would require that not less than $.5 million of such appropriation would be devoted to management and monitoring of the program.

Under current plans, projects at some 43 VA medical facilities have been identified for funding. Contracting with appropriate community based organizations should begin shortly. Outreach teams will identify eligible homeless veterans living in shelters and on the streets, and attempt to bring them into our medical centers where they will receive complete medical and psychiatric evaluations. When indicated some of these veterans will be placed by mutual agreement into community-based contracted therapeutic residential settings where they can receive services to help them become reintegrated into society. A system is also being set up to gather data to ensure the quality and extent of service delivery and to assess the overall effectiveness of the new programs.

Mr. Chairman, we have high hopes for the success of this program. We look forward to our initial evaluation of its impact on this target population.

BENEFICIARY TRAVEL

H.R. 2327 would amend the statutory authority for VA to furnish veterans with travel to and from a VA facility in connection with receipt of benefits, principally health care care benefits.

As you are aware, VA recently published regulations which significantly limited its beneficiary travel program. This bill would appear, in essence, to require that VA reinstitute beneficiary travel payments for modes of travel which were limited under those VA regulations. We strongly oppose this bill for the reasons I will discuss.

The bill would first change section 111(a) of title 38, United States Code, to provide that the Administrator "shall" rather than "may" pay for the necessary expense of travel of an "eligible claimant or beneficiary." It would add a new subsection specifying the individuals "entitled" to beneficiary travel payments. Included are veterans seeking care for a service connected disability; veterans with a service connected disability rated at least 50 percent; veterans in receipt of VA pension or whose income does not exceed the VA pension amount; veterans requiring, but unable to pay for a special mode of transportation such as an ambulance; veterans unable to defray the expenses of the travel as determined by the Administrator; and any other persons the Administrator determines, in accordance with regulation, should receive payment for travel. The bill would provide that travel may be paid for the purposes specified in the VA's regulations prior to their recent amendment,

and it would continue the statutory prohibition against payment of travel in excess of the cost of reasonably accessible public transportation, or in excess of that incurred by the beneficiary.

The VA's recently published regulations, which limited routine beneficiary travel payments, were the culmination of several years of effort to administratively control rapidly escalating expenditures for this travel. The basis for these efforts was the belief that routine, nonemergent travel payments could be scaled back without effectively denying veterans access to needed care, and that such funds could be more effectively devoted to providing direct health care for our veterans. In our view, the current regulations strike a fair balance, and accommodate many of the concerns of those who questioned the proposed change. The regulations continue to authorize VA to pay for all travel of veterans requiring a special mode of transportation to the hospital, such as an ambulance. To minimize the hardship on veterans living a great distance from a VA facility, the regulations provide that VA will pay for transportation costs in excess of a deductible amounting to $11.00. There are also other alternatives for delivering services to veterans which work to minimize the impact of travel costs, including contract hospitalization, fee basis outpatient care and outreach programs. Considering the strong basis for the regulatory changes, we oppose H.R. 2327 which would mandate a return to a system similar to that which existed prior to those changes. We believe the beneficiary travel program as it now exists after publication of the regulations should be left in place so it can be determined whether it meets the essential needs of veterans seeking VA health care benefits.

We estimate that the enactment and implementation of this measure would increase beneficiary travel payments by some $55.5 million annually over and above the costs we anticipate incurring under our regulations. Thus, we anticipate incurring total costs under the beneficiary travel program of $110 million in FY 88 and five-year costs of some $633 million. If this measure were to be effective during this fiscal year, additional costs in the range of $5 million/month could be expected.

READJUSTMENT COUNSELING PROGRAM

Mr. Chairman, you also requested that we present views on H.R. 2146, a bill which would postpone for one year the date by which the VA's Readjustment Counseling Program would have to be changed from a program taking place primarily in vet centers to a program taking place primarily in VA medical centers. Specifically the bill would amend section 612A(g) to postpone the transition date from October 1, 1989, to October 1, 1990. It would also amend that section to postpone for one year the dates by which the Administrator must submit various reports to the Veterans' Affairs committees of Congressregarding that change. Specifically, the bill would postpone the April 1, 1987, due date for a report in which the Administrator must evaluate and report on the effectiveness of the Readjustment Counseling Program in meeting the readjustment needs of Vietnam veterans, the extent to which readjustment needs of such veterans remain unmet, and the extent to which Vet Centers are required to meet this unmet need. The bill would also postpone the due date of a report presently due July 1, 1987, describing VA's plan for the transition of the Readjustment Counseling Program to one providing services primarily through VA medical centers, and a report presently due February 1, 1989, on VA's experience during the first year of the transition. Finally, the bill would require that the Administrator maintain and operate until October 1, 1988, the same number of vet centers that were in operation on April 1, 1987.

Mr. Chairman, we have no objection to postponing the transition date for the readjustment counseling program by one year. We strongly object, however, to the provision in this bill which would require that we continue to operate on a free standing basis, all of the Vet Centers in operation on April 1, 1987. As you are aware, VA is planning on relocating some nine Vet Centers to VA medical centers this fiscal year. This bill apparently seeks to rule out that action. Considering the fact that existing law (as well as this proposal) continue to require VA to relocate a majority of the Vet Centers in the near future, we believe it would be wise to proceed with this small-scale relocation. That will allow the Agency to gain experience and information which will be useful in planning the full transition required by law. Moreover, relocation of the specific centers was a deliberate initiative based on sound criteria. In selecting the Vet Center to be relocated, we considered

such factors as the distribution of Vietnam era veterans by census, the distance between the vet center and the VA medical facility. This was not arbitrary decisionmaking, but a well-conceived, practical effort to assure continued effective service delivery. We do not believe the interests of this program or its clients would be well served by statutorily freezing it in a particular configuration. Accordingly, we strongly urge that you not adopt this aspect of H.R. 2146.

MAJOR VA LEGISLATIVE PROPOSALS

As I indicated in my opening remarks, we are grateful that you have introduced draft legislation which we submitted to Congress this session. We welcome your active consideration of these measures. They include bills which would foster many of the goals this Committee stands for--providing VA the means to improve our health-care system, enabling it to administer health care more effectively, and to establish the most efficient management structures possible for that system.

Let me briefly highlight some of the measures we have initiated:

-H.R. 2001 would extend the agency's authority to provide adult day health care services, which will otherwise expire on September 30, 1988. We see this program as providing a very promising alternative to institutionalization.

-H.R. 2002 would solve a series of problems in ensuring that certain title 5 health-care personnel, such as x-ray, laboratory, operating room and other technologists and technicians are available inmedical emergencies or for unforeseen medical needs that occur outside their regular duty hours by authorizing the Administrator to pay "on call" pay to civil service health care personnel in the same manner that this pay is provided to title 38 registered nurses. Under this bill, VA could schedule these health-care personnel "on call" as necessary without instituting costly standby pay.

-H.R. 2003 would promote VA's medical research and education programs by providing the Chief Medical Director with additional flexibility to appoint nonlicensed practical or vocational nurses, physical therapists and registered nurses to research or academic assignments. The waiver authority embodied in the draft bill is not intended for, and would not be used in connection with, any person who would have any responsibility for any patient. The draft bill would also assist the VA outpatient clinic in Manila to provide quality health-care to veterans by permitting the appointment of temporary full or part-time practical or vocational nurses or physical therapists who are licensed only in the Philippines to serve in that facility.

-H.R. 2004 would clarify the authority of the Chief Medical Director or designee to accept, reject, or modify recommendations made by Professional Standards Boards as a result of their reviews of the performance of probationary medical professionals. Currently, the Chief Medical Director, who is the official responsible for the operation of the Department of Medicine and Surgery, plays no substantive role in this review process. This provision would clarify the intent of Congress that the Administrator has the power to prescribe by regulation both the procedures to be followed by the Board and the circumstances in which Board proceedings may be initiated and that final action in the review process should be taken by the Chief Medical Director. Also, this provision would authorize these Boards to recommend corrective action other than the requirement in section 4106 that an employee be removed for unsatisfactory performance. This proposal would provide flexibility to allow the reviewing body to tailor its recommendations to fit the particular circumstances of each case.

-H.R. 2006, entitled the "Veterans' Health Care Benefits Administration Act of 1987," would, through a series of amendments, remove statutory impediments that block access to VA care and help improve administration of VA medical programs. Among its provisions is a measure that would permit foreign nationals who were disabled while serving as members of U.S. armed forces to obtain VA-sponsored health care for those disabilities without regard to citizenship.

H.R. 2006 would also provide needed authority to arrange for emergency hospital care needed by veterans who have been undergoing community nursing home care at VA expense.

-H.R. 2007, entitled the "VA Health Care Amendments Act of 1987," would, for example, clear up a troublesome issue surrounding the definition of the term "nursing home care" to provide that that term includes both skilled and intermediate levels of care.

-H.R. 2010 would amend section 4103 of title 38, United States Code, to add flexibility in staffing the office of the Chief Medical Director (CMD). The provision would increase to two the number of authorized Associate Deputy Chief Medical Directors (ADCMD), and would broaden the categories of individuals who could serve in either of the two positions to include highly qualified nonphysicians with health-care management and hospital management backgrounds and skills. The number of authorized ACMD's would be reduced from eight to seven, partly because of the addition of the second ADCMD position. H.R. 2010 would also make discretionary much of the rigid structure now set forth in section 4103 by eliminating the requirement that specific Service Directors exist in the Office of Chief Medical Director. All of the changes in this bill would enhance the flexibility of the Chief Medical Director to organize the operation of the office in the way that best supports the needs of the Department's mission.

Mr. Chairman, this concludes our testimony. My colleagues and I would be pleased to respond to any questions you may have.

(Subsequently the Veterans Administration furnished the following information:)

At this point it would be appropriate to submit, for the record, a short synopsis of the Port Richey clinic and its scheduling policies.

The VAOPC, Port Richey FL (also called the 'Pasco Clinic') is a small primary care facility providing General Medical care which, until recently, has had only 2.5 physicians. It opened in late August of 1985 as the expansion of an earlier proposal to serve the many veterans of the area with a mobile clinic. In FY 1986, it was assigned a workload of 6800 outpatient visits and accomplished 7153. Since the clinic is quite small and offers a limited range of clinical services, it was agreed from the beginning that it would operate on a scheduled appointment basis only.

The clinic's workload figures through the first two quarters of FY 1987 are as follows:

SC (greater than 50%):	40.7%
SC (less than 50%)	52.0%
A&A, HB, WWI, POW	7.0%
	99.7%

At this time, there are approximately 300 service connected veterans on the waiting list. The clinic policy is, and has been since its inception, that non-emergent patients in one of the catesories listed above are evaluated to determine if the care they require can be provided at Port Richey in the future. If it can, and the patient does not wish to go to the VAMC Tampa for the care, they are placed on a waiting list. If not, they are referred to the Tampa hospital. Veterans (SC or NSC) presenting with any symptoms of distress are evaluated by a nurse or M.D., and, if necessary, transported to Tampa, or even a nearby community hospital, on an emergency basis. Humanitarian emergencies are also (rarely) seen there. It must be noted that the clinic policy with regard to NSC veterans has been well publicized in the veteran community since the opening of the clinic. The NSC veterans generally know that they cannot be seen at this clinic and do not present themselves. On the rare occasion that an NSC veteran, who is not in medical distress, presents himself at the clinic, he is referred to the Tampa VAMC.

The substantial expansion that is currently being planned will enable the clinic to eliminate the current waiting list and to increase its workload to many other service connected veterans within the surrounding community.

(Subsequently, the Veterans Administration furnished the following information:)

As discussed with committee staff, the question relates to Columns G-J of our monthly report on disposition of applicants.

The following is an explanation of columns G - J on the monthly report (copy attached) on applications:

Col. G - Cancelled. This disposition is used for applicants who withdraw their application or who fail to complete their medical examination before need for medical care can be established by the examining physician. An example would be a veteran who walks out of the waiting room before seeing the physician.

Col. H - Not Eligible. This disposition is used for applicants who are determined to be ineligible because they fail to meet a legal requirement. An example would be a veteran who enlisted in the armed forces after 1980, who received an honorable discharge, but who failed to complete 24 months of active duty and who was not discharged for one of the extenuating circumstances contained in 38 USC 3103A.

Col. I - Treatment Modality Not Available. This disposition has both an inpatient and an outpatient component. Concerning inpatients, each VA medical center has been instructed to locate needed medical care for a Category "A" veteran within the VA system. The medical care is sometimes a considerable distance from the veteran's family and friends. Under these circumstances, veterans eligible for contract hospitalization under 38 USC section 603 could be furnished the needed services in the community at VA expense. Veterans not eligible for fee basis care believe frequently that VA care is an inconvenience to the family and choose to seek non-VA care at personal expense. When such veterans turn down VA's offer of inpatient medical care and instead seek care in the community, the VA has no authority to provide this treatment modality. Such cases are reported under this disposition.

Regarding outpatients, each VA medical center follows our policy of providing outpatient care within existing resources. P.L. 99-272 did not establish a requirement directing VA to provide all Category "A" veterans outpatient care. Consequently, when a VA health care facility cannot provide outpatient care to a nonservice-connected veteran, and the veteran is ineligible for fee basis care under 38 USC section 603, he or she is referred to local resources at personal expense. When this is done, it is most often because the VA has been unable to employ the appropriate subspecialty physician to adequately treat the veteran. These cases also are reported under this heading.

Col. J - Referred to Other Facility. This disposition is used for applicants who are determined to be in need of a level or modality of treatment which is not available at the VA facility to which they originally applied and the facility processing the original application makes arrangements for the applicant to be seen at anotner VA medical center with appropriate facilities. An example would be a veteran who applies at VAMC "A" who is determined to be in need of orthopedic surgery; VAMC "A" does not have a surgical service and arranges for the veteran to be seen at VAMC "B" which does.

As can be seen, the total of these columns does not represent veterans being turned away, but other appropriate dispositions.

TOTAL ALL STATIONS

MEDICAL ADMINISTRATION SERVICE
VETERAN ELIGIBILITY AND THE FURNISHING OF HEALTH CARE
FOR MONTH ENDING JUN 30, 1987

8ZT1

	VETERAN ELIGIBILITY	NUMBER OF APPLICATIONS A	---CARE RECEIVED/SCHEDULED--- HOSP. B	NURSING HOME CARE C	DOM D	OUTPAT CARE E	MEDICALLY EXAMINED-NO FURTHER CARE REQ F	CANCELED G	NOT ELIGIBLE H	TREATMENT MODALITY NOT AVAIL I	REF TO OTHER FAC J	PENDING EOM K	NOT AGREEING TO DEDUCT L	ITEM A AS % OF GRAND TOTAL M	OUT OF BAL N
	CATEGORY A														
01	100% SERVICE CONNECTED	14,857	4,136	39	31	9,535	491	333	17	7	59	100		6.15	5
02	90% SERVICE CONNECTED	572	124	1		409	12	17	5		4	4		.24	
03	80% SERVICE CONNECTED	1,605	338	4	1	1,066	65	22	8	1	4	11		.67	99
04	70% SERVICE CONNECTED	3,328	822	4	1	2,476	107	86	14		18	36		1.40	202-
05	60% SERVICE CONNECTED	5,042	1,165	10	6	3,553	163	99	21		23	17		2.12	
06	50% SERVICE CONNECTED	5,996	1,383	5	9	4,189	224	133	19	1	31	24		2.52	3
07	TOTAL 50% THRU 100% S C	31,200	7,968	63	48	21,228	1,062	690	82	9	139	192		13.10	95-
08	40% SERVICE CONNECTED	6,195	1,322	11	53	4,393	234	131	27	5	18	14		2.60	2
09	30% SERVICE CONNECTED	10,268	2,246	13	37	7,286	397	205	33	5	38	26		4.31	2
10	20% SERVICE CONNECTED	8,918	1,680	11	17	6,614	302	190	48	13	38	18		3.74	7
11	10% SERVICE CONNECTED	19,071	3,546	31	33	15,145	886	394	59	9	60	27		8.00	887-
12	0% SERVICE CONNECTED	16,200	3,912	18	34	11,238	544	323	49	14	53	21		6.80	2
13	OTHER SERVICE CONNECTED	1,386	130	1	2	1,195	22	23	9		6	3		.58	
14	TOTAL 0% - 40% & OTH S C	62,038	12,838	85	176	45,871	2,185	1,276	225	46	213	107		26.04	874-
15	TOTAL (ITEMS 7 & 14)	93,238	20,804	148	224	67,099	3,247	1,966	307	55	352	299		39.13	969-
16	FORMER PRISONER OF WAR	987	167	1		766	28	11	2	1	9	2		.41	
17	AGENT ORANGE/IONIZING RAD	5,103	1,143	9	10	3,816	164	135	9	4	11	1		2.14	2
18	WORLD WAR I	1,765	622	33	2	1,016	45	26	11		8	7		.74	2
19	VA PENSIONER	25,716	8,349	98	64	15,597	944	511	47	13	92	29		10.79	4
20	MEDICAID	1,609	460	2	4	1,041	43	54	2	1	3	1		.68	
21	OTHER NSC CATEGORY A	91,690	22,517	170	199	62,235	3,684	2,177	286	89	239	129		38.48	88
22	TOTAL (ITEMS 16 THRU 21)	126,870	33,258	313	279	84,271	4,908	2,914	359	108	362	169		53.25	94
23	CATEGORY A TOTAL (ITEMS 15 & 22)	220,108	54,062	461	503	151,370	8,155	4,880	666	163	714	468		92.38	875-
24	CATEGORY B OTHER NSC	7,833	1,829	22		5,505	296	153	6	9	15	7		3.29	4-
25	CATEGORY C OTHER NSC	7,090	1,508	15		5,007	296	204	9	9	10	4	27	2.98	7
26	TOTAL CATEGORIES A, B, C	235,031	57,397	498	503	161,882	8,747	5,237	681	181	739	479	27	98.65	878-
27	ALL NON-VETERAN APPLICANTS	3,225												1.35	
28	GRAND TOTAL	238,256	57,397	498	503	161,882	8,747	5,237	681	181	739	479	27	100.00	878-
29	PERCENT OF GRAND TOTAL	100.00	24.09	.21	.21	67.94	3.67	2.20	.29	.08	.31	.20	.01		.37

NOTE: 1. COLUMN L IS FOR CATEGORY C ONLY.
2. COLUMN N - APPLICATIONS (COLUMN A) PLUS PRIOR MONTH'S PENDING EQUALS THE SUM OF COLUMNS B THRU L - AN OUT OF BALANCE WILL OCCUR.

Adjusted 7/13/87

(Subsequently, the Veterans Administration furnished the following information:)

The Department of Medicine and Surgery currently has a task force that is charged with studying recruitment and retention problems and with identifying long-term solutions to those problems. Bonuses are one tool being considered by the task force for meeting employment needs in various health care occupations including registered nurses. The group will consider both positive and negative aspects of a bonus program.

A bonus system would allow pinpoint targeting of dollars to specific recruitment and retention needs, and it could be approved and terminated in response to rapid changes in staffing needs. This "turn on, turn off" factor is complemented by the fact that bonuses would not affect employees' basic pay. This means that using the bonus mechanism would not create a permanent increase in payroll. Bonuses would also allow VA to better compete for nursing services with those private sector hospitals which now pay bonuses.

On the other hand, a bonus system that only provides bonuses to registered nurses and not for other occupations experiencing severe recruitment and retention problems could be considered inequitable. Further, it may be that funds would be better spent in other more effective recruitment and retention programs, such as tuition reimbursement.

For these reasons, the VA would prefer to wait until the Task Force has completed its initial report and submitted its analysis and recommendations before endorsing a recruitment and retention program such as the proposed nurse bonus program.

(Subsequently, the Veterans Administration
furnished the following information:)

The VAMC Tampa researched the record of the patient in question and determined that he was a 70% Service-connected veteran who had never required VA services of any kind prior to his episode of December 29, 1986. He was admitted to a private sector hospital, (St. Joseph's Hospital) and underwent a surgical procedure to evacuate an abcess and to remove discs in the cervical area. This hospitalization was not related to his service-connected disability (amputation- right leg). The patient did not contact any VA medical center or outpatient clinic to seek VA medical care, nor did he ask for authorization to seek non-VA medical care. As he chose, of his own accord, to utilize a non-VA source for an ailment not related to his service-connected disability, the VA was unable to pay for the services received. Had he gone to the outpatient clinic at Port Richey or to the VAMC Tampa, he would have been made aware of these regulations and may have avoided the cost of his inpatient stay at St. Joseph's Hospital. The patient was transferred to the Tampa VAMC on January 22, 1987 and was discharged on February 18,1987.

(Subsequently, the Veterans Administration furnished the following information:)

Since P.L. 98-528 was enacted in October 1984, the Agency has been unable to meet the reporting dates for the annual reports on Post-traumatic Stress Disorder which are mandated by Section 110 of that legislation. Among other things, the Agency's report is required to include the Chief Medical Director's views on the Special Committee for PTSD's recommendations concerning diagnostic and treatment activities for veterans with PTSD.

The Agency's first report was due for submission to Congress on March 1, 1985. The Special Committee on PTSD was established in December 1984, and submitted a report to the Chief Medical Director containing 33 recommendations on January 25, 1985. The Agency's first report which provided the Chief Medical Director's views on the Special Committee's recommendations was written, received concurrences within the Department of Medicine and Surgery and other Agency offices, was signed by the Administrator and sent to OMB in October 1985. OMB requested minor changes and approved the report for release to Congress in February 1986.

The second Agency report was due to Congress on February 1, 1986. The Special Committee on PTSD provided its second report containing 65 recommendations to the Chief Medical Director on February 1, 1986. The Agency's second report was written to reflect the Chief Medical Director's views on the Special Committee's recommendations and was signed by the Administrator and sent to OMB on November 20, 1986. OMB requested changes and, following a second review, approved the second Agency report for submission to Congress on April 6, 1987.

The Special Committee submitted its third report to the Chief Medical Director on February 1, 1987. The Agency's third report has been prepared and is being reviewed within and outside the Department of Medicine and Surgery prior to submission to the Administrator for signature. We expect that the Agency's third report will be transmitted to Congress by September 1987.

We have requested that the Special Committee submit its recommendations in its fourth report to the Chief Medical Director earlier than February 1, 1988. If the Special Committee can accommodate this request, then the Agency will be able to complete its fourth report and submit it to Congress at the designated time.

(Subsequently, the Veterans Administration furnished the following information:)

The relevant sequence of events in preparation for and in final submission of the nine vet centers to be relocated to VA health care facilities is documented below. Early in October, 1986 the Director for Operations and the Director, Readjustment Counseling Service discussed a demonstration project for moving a small and select number of vet centers to medical facilities, and concurred on the advisability of such a project. Readjustment Counseling Service (RCS) initiated the development of selection criteria for these planned moves. Suggested criteria were reviewed, discussed, and finalized by RCS officials during their October, 1986 staff meeting with regional management. By early November, 1986 the completed criteria were forwarded to the Director for Operations for review and approval. Also early in November, 1986 RCS initiated the process of evaluating preliminary sites suggested by the field as those most feasible for relocation. A working list of suggested sites was formulated by RCS and forwarded to the Director for Operations.

Formal DM&S approval of the criteria for the vet center relocation project was obtained on January 13, 1987 following review and approval by the DM&S Policy Advisory Board (PAB). The Chief Medical Director concurred with the action of the PAB, and signed the document on January 20, 1987. After frequent coordination between RCS officials and Deputy Regional Directors, the list of nine vet centers currently planned for relocation was submitted to the Chief Medical Director on January 23, 1987. These sites were subsequently approved by the Administrator on January 28, 1987.

TESTIMONY OF THE HONORABLE TIM JOHNSON
BEFORE THE HOSPITAL AND HEALTH CARE SUBCOMMITTEE
CHAIRMAN SONNY MONTGOMERY
MAY 20, 1987

Mr. Chairman and members of the Subcommittee, I would like to thank you for permitting me to comment on the issues before you, and to congratulate you for holding such timely hearings on matters of such importance to our veteran community. Two issues that directly impact my veteran constituents in the state of South Dakota are Beneficiary Travel, which is addressed in HR 2327, sponsored by the ranking minority member Gerald Solomon, and that of an extension for the transition period of the VA readjustment counseling centers, outlined in HR 2146, sponsored by Lane Evans. Both are excellent pieces of legislation and I commend both congressmen for introducing them.

Beneficiary travel is of the utmost importance to veterans in rural states like South Dakota. In some cases, vets live close to 200 miles from the VA medical center where they are entitled to receive treatment. For some of these men and women, the cost of traveling to the VA medical centers is prohibitive. Because they cannot afford the trip without some assistance from the VA, they are effectively being denied their deserved benefits. I applaud the actions of Representative Solomon and the 138 congressmen and women who have joined me in cosponsoring this badly-needed legislation. Travel payments have been made to vets in the past, and this bill would rightly restore them to many needy veterans.

Another issue in my state is the proposed relocation of the Veterans' Outreach Center in Sioux Falls. This center provides counseling and job advice for any Vietnam era vet who needs it, in a downtown, accessible location and in a comfortable, non-threatening atmosphere. The VA has targeted nine of these centers to be relocated to the grounds of the VA medical center, which may have detrimental effects on the services the center is able to offer. Congress has requested reports on the possible effect the relocation would have, and these reports have not yet been received. HR 2146 would move the relocation date back by one year and would stipulate that the current number of Outreach Centers would remain intact. It is only fitting that no action be taken until we in Congress have all the information concerning the effects of the relocation, so that we can make an intelligent decision. I commend Representative Evans for sponsoring this legislation, and I respectfully urge all members of this Subcommittee and the Committee to support it.

LEGISLATIVE STATEMENT OF THE BLINDED VETERANS ASSOCIATION

AS SUBMITTED BY

ROBERT ROUTH, JR., NATIONAL PRESIDENT

Mr. Chairman and Members of the Subcommittee:

On behalf of the Blinded Veteras Association (BVA), I want to express our appreciation for the opportunity to submit this written statement for the record of your Hospital and Health Care Subcommittee Hearing of May 20, 1987. As you know, the BVA has great interest in the Veterans Administration (VA) health care programs and any legislation that could improve the quality of those programs and services. This year we have expressed grave concerns regarding the change in VA regulations governing Beneficiary Travel Benefits and the extremely adverse affect thay have had on blinded veterans. We are therefore especially pleased to have this opportunity to comment in depth on the legislative initiatives before you, particularly H.R. 2327, which would restore beneficiary travel benefits.

Before commenting on H.R. 2327, we do want to express our support for H.R. 2001, 2002, 2003, 2004, 2006, 2007, and 2010. We have some reservations however, regarding H.R. 2010, which would authorize the Chief Medical Director (CMD) to abolish certain Director positions in VA Central Office. Our concern is for the smaller services and programs that might be eliminated as cost savings efforts which provide service for very special populations of disabled veterans such as Blind Rehabilitation Service (BRS). We would also oppose the elimination of the ACMD for Extended Care and Geriatric Service. With rapidly increasing population of older veterans and the special needs which accompany aging, we feel this service is criticle to coordinating and directing vital research into the entire range of medical, psychological and social problems associated with the aging process. The VA can and should be the leader in this crucial effort and the elimination of the position of ACMD would not, in our opinion, enhance that effort.

The BVA would also like to be on record as supporting H.R. 2146, which would extend the transition period for the Vietnam Veterans Community based centers. Any effort that might enhance an orderly transition maximizing the continuation of the treatment being offered, while minimizing the loss of veterans receiving such treatment because of the physical relocations, is definitely worthwhile.

Finally Mr. Chairman, I would like to comment on H.R. 2327. The VA Beneficiary Travel Program is absolutely criticle to blinded veterans and other disabled veterans, particularly those who require treatment which is only provided in Regional Specialized Medical Programs. H.R. 2327, which we wholeheartedly support, rectifies the gross inequities imposed by the newly implemented VA regulations governing Beneficiary Travel Benefits.

When the new regulations were initially proposed last fall, blinded veterans would have been required to pay their own travel expenses to and from Blind Rehabilitation Centers and Clinics. In most cases, this would involve the use of common air carriers because of the long distances involved. As you know, there are only 7 blind rehab facilities in the Continental U.S., so travel distances to the appropriate centers or clinics can be quite long and expensive. As the result of protests by BVA and other Veterans Service Organizations, the proposed regs were modified after the public comment period, and provisions were made for the VA to cover the expense of travel to and from such Regional Specialized Medical Programs. However, this modificaiton established a 100 mile radius from VA medical facilities, within which the VA would not reimburse travel expenses. This has had a negative impact on the VA Visual Impairment Services Team (VIST) Program. Blinded veterans who previously had their travel expenses reimbursed or were provided transportation by VA, no longer have access to the VIST Program. The comprehensive services delivered through this program are critical to the veteran's ability to maintain his independence. H.R. 2327 corrects this problem as well as eliminating the deductible blind vets would have to pay under the newly implemented regs for travel to and from blind rehab facilities. Our only concern with H.R. 2327 is that those veterans whose income is above the pension limit would still be required to pay their own travel expenses. As mentioned, travel to Regional Specialized Medical Programs, usually requiring common air carrier, can be very expensive; due at least in part to the fact the one way tickets must be purchased eliminating the savings that can be realized from Super Saver and other discount fares. Several hundred dollars can be significant for veterans on limited incomes, despite being above the pension limit.

Blindness, whether it be sudden and traumatic or a gradual loss, is an extremely severe disability which many veterans have great difficulty in accepting and dealing with in an appropriate manner. Adjustment to sight loss is a primary function of and benefit from blind rehabilitation and the residential nature of the VA Blind

Rehab Program provides the optimum environment for this acceptance and adjustment to take place. Unfortunately however, individuals who are newly blinded or in the process of losing their vision are not always highly motivated for blind rehab because they may have many of the old stereotypic notions that blind people cannot do anything; they do not want to have to leave the security of their home and family; and they lack understanding of how beneficial blind rehab can be. The financial burden of having to pay travel expenses becomes a convenient excuse not to attend the training that can be so beneficial to that individual and the VA. We feel it is beneficial to the VA and can be cost effective in the long run, because if that veteran can make an appropriate adjustment to his disability and develop the skills necessary to function independently, this will reduce his dependency on the VA and enable him to take better care of himself medically and psychologically. Able to do this, he will be less likely to require hospitalization or nursing home placement because of his blindness. Therefore, the combination of fragile motivation and the travel expense serve as deterants to his successful rehabilitation. In this case, the lack of beneficiary travel payments would serve to deny these veterans access to treatment for which they are eligible. Mr. Chairman, because of the special nature of this category of severe disabilities that are treated in Regional Specialized Medical Programs, Beneficiary Travel Benefits should be provided for this relatively small group of veterans.

Again Mr. Chairman, I want to thank you for this opportunity to submit our written statement on this important legislation affecting the ability of VA to provide quality health care services to our nation's disabled veterans. As always, the BVA stands ready to work with you and the other members of the Subcommittee and the Full Committee on these or any other peices of legislation on veterans affairs. We appreciate your leadership and efforts on behalf of all veterans and want to thank you and Mr. Solomon for sponsoring this extremely important legislation on Beneficiary Travel.

Robert Routh, Jr.
National President, BVA

STATEMENT OF

DAVID J. PASSAMANECK

NATIONAL LEGISLATIVE DIRECTOR

AMVETS

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

ON

H.R. 2001, 2002, 2003, 2004, 2006, 2007, 2010, 2327, 2146

AS WELL AS SEVERAL DRAFT BILLS

20 MAY 1987

Mr. Chairman, the American Veterans of World War II, Korea and Vietnam (AMVETS) is pleased to present our views regarding draft legislation which would:

(1) Require that the VA shall provide outpatient medical services to veterans eligible for needed hospital care under "Category A" criteria;

(2) Link eligibility for VA domiciliary care to inability to defray expenses of such care;

(3) Modify procedures for disciplinary boards;

(4) Expand eligibility for health professional scholarship program to occupations included in Section 4104 of Title 38, United States Code;

(5) Establish a pilot program on hospital management efficiency; and,

(6) Include pharmacists under the title 38 personnel system for appointment and pay purposes similar to the status of physical therapists as established by Public Law 98-160.

In addition, testimony on H.R. 2001, H.R. 2002, H.R. 2003, H.R. 2004, H.R. 2006, H.R. 2007, H.R. 2010, H.R. 2327 and H.R. 2146 was requested.

We enthusiastically support enactment of the draft legislation and the bills as summarized and listed above. These measures will serve to avoid existing ambiguities and misinterpretations of criteria for health care eligibility and improve the efficiency of the VA's Department of Medicine and Surgery.

We particularly wish to urge enactment of H.R. 2146 and H.R. 2327.

H.R. 2146 would amend Title 38, U.S.C., to extend the transition period for the VA's Vet Center program and in effect call a halt to relocation of the nine centers now scheduled to be colocated with medical centers. Of the nine centers, two transitions are going well; however, four are proceeding badly and three centers are proceeding poorly. There is ample evidence for this transition, at this time being reevaluated. Further, as you may be aware, the Senate recently passed a measure which would delay the transition of the centers. AMVETS urges swift action on H.R. 2146 not only because the transition schedule is going badly, but also because at least three centers face end of lease agreements in June. This contingency worsens a bad situation threatening program disruption and uncertainty.

H.R. 2327 would prevent the VA from administratively cutting off beneficiary travel and assure its availability for those disabled veterans who need it the most.

JUL 1987

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

JUL 8 1987

Honorable G. V. (Sonny) Montgomery
Chairman, Committee on Veterans'
Affairs
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Enclosed please find the Agency's responses to the questions which you forwarded on behalf of Representative John Paul Hammerschmidt and yourself for the May 20, 1987, hearing by the Subcommittee on Hospitals and Health Care. Thank you for the opportunity to provide this additional information for the record.

Sincerely,

THOMAS K. TURNAGE
Administrator

Enclosure

CONGRESSMAN MONTGOMERY

Question: 1. We might consider creating an incentive payment arrangement to recruit nurses to the VA that would be triggered by a 10 percent or greater vacancy rate for registered nurses at a medical center.

Do you feel that a 10 percent rate is too high or too low?

Answer: We do not believe that a particular vacancy rate should be used as a "trigger" for an incentive payment program designed to relieve nurse recruiting and retention problems. Using a particular vacancy rate as a "trigger" would be overly prescriptive; it would not account for the variety of different local situations that would reflect nurse staffing difficulties. For instance, a 10% vacancy rate at a facility with a large OR staff would not be as devastating as a 10% vacancy rate at a facility with only 8 to 10 OR nurses. There are a number of possible indicators that could be used to determine when a recruitment bonus is needed; rates are just one of several criteria. Criteria which do reflect the variety of local situations would best be established in regulation rather than prescribed in statute. This would permit the VA to consider the specifics of each situation.

Question: 2. Would such a rate take into sufficient account the relative shortages in specific nursing specialty areas such as intensive care and operating rooms?

Answer: As previously indicated, a 10% vacancy rate, or any other specifically designated indicator or trigger, may not sufficiently recognize the particular local situation, either with respect to nursing specialty areas or other factors. For this reason, VA feels that it would be best if the statute only required that criteria be established in regulation

Question: 3. Do you feel that tying incentive payments to agreements to sign contracts to work for 2, 3 or 4 years would be a useful approach to the problem of nurse recruitment?

Answer: A "payback" requirement in the form of guaranteed service would be best determined based on the amount of the particular bonus granted to the individual nurse at a specific facility. Once again, permitting the VA flexibility to establish criteria for determining length of service contracts would allow for appropriate consideration of each case.

Question: 4. Do you feel that penalties in connection with the contract would affect the interest of nursing candidates to work for the VA?

Answer: The extent of the penalties could become a disincentive. When a nurse is shopping for an employer, the bonus penalties may be compared and may become a consideration in the decision-making process. Another problem could develop if this bonus were only paid to "new hire" nurses. While it may have a positive impact on the VA's ability to recruit, it may in turn adversely impact on the retention of nurses already on staff who were not afforded the benefit of a hire-on bonus. For this reason, the VA believes that it would be beneficial to provide the option for the agency to determine when it is appropriate to extend payment of the bonus to encourage retention, as well as recruitment.

Question: 5. H.R. 2002 would authorize "on call" pay to certain civil service health-care personnel at a rate equal to 10 percent of the hourly overtime rate for services in excess of the regular duty period. How does this "on call" situation work in the non-VA hospital sector?

Answer: The VA does not have any systematic information on non-VA practices with respect to on-call pay, particularly for health care personnel other than nurses. However, significant anecdotal information indicates that hourly on-call pay is a common practice in the private hospital sector and is used in order to ensure the availability of the necessary personnel in emergent situations. Many major metropolitan facilities do not use on-call pay extensively because they can predictably staff the emergency areas on a 24-hour basis, something that is not practical or advisable for most VAMCs.

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

- [illegible] improvement of identification criteria for pharmacist positions;
- investigation of expanded use of cooperative education programs for pharmacists;

CONGRESSMAN HAMMERSCHMIDT

will be considered prima facie evidence of adequate means of support. This policy is subject to rebuttal by the Medical Center Director by showing that such income is not adequate to provide the care required or that the income is not available for the veteran's use because of other obligations. In all such cases of alleged inadequate means of support, the circumstances are to be submitted to the Director for decision and documented in the appropriate administrative records.

As is noted above, current legislative authority allows the granting of an income limitation waiver in those instances where it can be shown that a service-connected or nonservice connected veteran in receipt of income in excess of $415 per month requires but cannot defray the costs of domiciliary care services.